

105TH CONGRESS  
2D SESSION

# H. R. 4250

To provide new patient protections under group health plans.

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## IN THE HOUSE OF REPRESENTATIVES

JULY 16, 1998

Mr. GINGRICH (for himself, Mr. HASTERT, Mr. ARCHER, Mr. BLILEY, Mr. GOODLING, Mr. BILIRAKIS, Mr. FAWELL, Mr. NORWOOD, Mr. McCRERY, Mr. HOBSON, Mr. GOSS, Ms. PRYCE of Ohio, Mrs. KELLY, Mr. TALENT, Ms. GRANGER, Mr. CHAMBLISS, Mr. GILCHREST, Mr. WELDON of Florida, Mr. METCALF, Mr. PETERSON of Pennsylvania, Mr. TIAHRT, Mr. BARTLETT of Maryland, Mr. BUNNING, Mrs. NORTHUP, Mr. HUTCHINSON, Mr. GIBBONS, Mr. CHABOT, Mr. BOEHNER, Mr. GREENWOOD, Mrs. FOWLER, Mr. SPENCE, Mr. DUNCAN, Mr. SKEEN, Mr. HERGER, Mrs. CUBIN, Mr. DREIER, Mr. UPTON, Mr. COLLINS, Mr. SESSIONS, Mr. FOLEY, Mr. GILLMOR, Mr. ENGLISH of Pennsylvania, Mr. REDMOND, Mr. ROGERS, Mr. SMITH of Michigan, Mr. MICA, Mr. ADERHOLT, Mr. LATHAM, Mr. FOX of Pennsylvania, Mr. McKEON, Mr. GALLEGLY, Mr. TAUZIN, Mr. NEY, Mr. HILLEARY, Mr. PAXON, Mr. BALLENGER, Mr. KASICH, and Mr. REGULA) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, Ways and Means, the Judiciary, and Government Reform and Oversight, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To provide new patient protections under group health plans.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—The Act may be cited as the  
3 “Patient Protection Act of 1998”.

4 (b) TABLE OF CONTENTS.—The table of contents is  
5 as follows:

Sec. 1. Short title and table of contents.

**TITLE I—AMENDMENTS TO THE EMPLOYEE RETIREMENT  
INCOME SECURITY ACT OF 1974**

**Subtitle A—Patient Protections.**

Sec. 1001. Patient access to unrestricted medical advice, emergency medical  
care, obstetric and gynecological care, and pediatric care.

Sec. 1002. Effective date and related rules.

**Subtitle B—Patient Access to Information**

Sec. 1101. Patient access to information regarding plan coverage, managed  
care procedures, health care providers, and quality of medical  
care.

Sec. 1102. Effective date.

**Subtitle C—New Procedures and Access to Courts for Grievances Arising  
under Group Health Plans**

Sec. 1201. Special rules for group health plans.

Sec. 1202. Effective date.

**Subtitle D—Affordable Health Coverage for Employees of Small Businesses**

Sec. 1301. Short title of subtitle.

Sec. 1302. Rules governing association health plans.

**“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS**

“Sec. 801. Association health plans.

“Sec. 802. Certification of association health plans.

“Sec. 803. Requirements relating to sponsors and boards of trustees.

“Sec. 804. Participation and coverage requirements.

“Sec. 805. Other requirements relating to plan documents, contribution  
rates, and benefit options.

“Sec. 806. Maintenance of reserves and provisions for solvency for plans  
providing health benefits in addition to health insurance  
coverage.

“Sec. 807. Requirements for application and related requirements.

“Sec. 808. Notice requirements for voluntary termination.

“Sec. 809. Corrective actions and mandatory termination.

“Sec. 810. Trusteeship by the secretary of insolvent association health  
plans providing health benefits in addition to health insur-  
ance coverage.

“Sec. 811. State assessment authority.

- “Sec. 812. Special rules for church plans.
- “Sec. 813. Definitions and rules of construction.
- Sec. 1303. Clarification of treatment of single employer arrangements.
- Sec. 1304. Clarification of treatment of certain collectively bargained arrangements.
- Sec. 1305. Enforcement provisions relating to association health plans.
- Sec. 1306. Cooperation between Federal and State authorities.
- Sec. 1307. Effective date and transitional and other rules.

## TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

### Subtitle A—Patient Protections and Point of Service Coverage Requirements

- Sec. 2001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.
- Sec. 2002. Requiring health maintenance organizations to offer option of point-of-service coverage.

### Subtitle B—Patient Access to Information

- Sec. 2101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.
- Sec. 2102. Reporting on fraud and abuse enforcement activities.
- Sec. 2103. Effective date.

### Subtitle C—HealthMarts

- Sec. 2201. Short title of subtitle.
- Sec. 2202. Expansion of consumer choice through HealthMarts.

## “TITLE XXVIII—HEALTHMARTS

- “Sec. 2801. Definition of HealthMart.
- “Sec. 2802. Application of certain laws and requirements.
- “Sec. 2803. Administration.
- “Sec. 2804. Definitions.

### SUBTITLE D—COMMUNITY HEALTH ORGANIZATIONS

- Sec. 2301. Promotion of provision of insurance by community health organizations.

## TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

### Subtitle A—Patient Protections

- Sec. 3001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.
- Sec. 3002. Effective date and related rules.

### Subtitle B—Patient Access to Information

- Sec. 3101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.
- Sec. 3102. Reporting on fraud and abuse enforcement activities.
- Sec. 3103. Effective date.

Subtitle C—Medical Savings Accounts

- Sec. 3201. Expansion of availability of medical savings accounts.
- Sec. 3202. Exception from insurance limitation in case of medical savings accounts.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

- Sec. 4001. Federal reform of health care liability actions.
- Sec. 4002. Definitions.
- Sec. 4003. Effective date.

Subtitle B—Uniform Standards for Health Care Liability Actions

- Sec. 4011. Statute of limitations.
- Sec. 4012. Calculation and payment of damages.
- Sec. 4013. Alternative dispute resolution.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

- Sec. 5001. Confidentiality of protected health information.

“PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

- “Sec. 1181. Inspection and copying of protected health information.
- “Sec. 1182. Supplementation of protected health information.
- “Sec. 1183. Notice of confidentiality practices.
- “Sec. 1184. Establishment of safeguards.
- “Sec. 1185. Availability of protected health information for purposes of health care operations.
- “Sec. 1186. Relationship to other laws.
- “Sec. 1187. Civil penalties.
- “Sec. 1188. Definitions.
- Sec. 5002. Study and report on effect of State law on health-related research.
- Sec. 5003. Study and report on State law on protected health information.
- Sec. 5004. Protection for certain information developed to reduce mortality or morbidity or for improving patient care and safety.

TITLE VI—MEDICAL SAVINGS ACCOUNTS FOR FEDERAL EMPLOYEES

- Sec. 6001. Medical savings accounts for Federal employees.
- Sec. 6002. Effective date.

1 **TITLE I—AMENDMENTS TO THE**  
 2 **EMPLOYEE RETIREMENT IN-**  
 3 **COME SECURITY ACT OF 1974**  
 4 **Subtitle A—Patient Protections**

5 **SEC. 1001. PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
 6 **ADVICE, EMERGENCY MEDICAL CARE, OB-**  
 7 **STETRIC AND GYNECOLOGICAL CARE, AND**  
 8 **PEDIATRIC CARE.**

9 (a) IN GENERAL.—Subpart B of part 7 of subtitle  
 10 B of title I of the Employee Retirement Income Security  
 11 Act of 1974 is amended further by adding at the end the  
 12 following new sections:

13 **“SEC. 713. PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
 14 **ADVICE, EMERGENCY MEDICAL CARE, OB-**  
 15 **STETRIC AND GYNECOLOGICAL CARE, PEDI-**  
 16 **ATRIC CARE.**

17 **“(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
 18 **ADVICE.—**

19 **“(1) IN GENERAL.—**In the case of any health  
 20 care professional acting within the lawful scope of  
 21 practice in the course of carrying out a contractual  
 22 employment arrangement or other direct contractual  
 23 arrangement between such professional and a group  
 24 health plan or a health insurance issuer offering  
 25 health insurance coverage in connection with a group

1 health plan, the plan or issuer with which such con-  
2 tractual employment arrangement or other direct  
3 contractual arrangement is maintained by the pro-  
4 fessional may not impose on such professional under  
5 such arrangement any prohibition with respect to  
6 advice, provided to a participant or beneficiary  
7 under the plan who is a patient, about the health  
8 status of the participant or beneficiary or the medi-  
9 cal care or treatment for the condition or disease of  
10 the participant or beneficiary, regardless of whether  
11 benefits for such care or treatment are provided  
12 under the plan or health insurance coverage offered  
13 in connection with the plan.

14 “(2) HEALTH CARE PROFESSIONAL DEFINED.—  
15 For purposes of this subsection, the term ‘health  
16 care professional’ means a physician (as defined in  
17 section 1861(r) of the Social Security Act) or other  
18 health care professional if coverage for the profes-  
19 sional’s services is provided under the group health  
20 plan for the services of the professional. Such term  
21 includes a podiatrist, optometrist, chiropractor, psy-  
22 chologist, dentist, physician assistant, physical or oc-  
23 cupational therapist and therapy assistant, speech-  
24 language pathologist, audiologist, registered or li-  
25 censed practical nurse (including nurse practitioner,

1 clinical nurse specialist, certified registered nurse  
2 anesthetist, and certified nurse–midwife), licensed  
3 certified social worker, registered respiratory thera-  
4 pist, and certified respiratory therapy technician.

5 “(b) PATIENT ACCESS TO EMERGENCY MEDICAL  
6 CARE.—

7 “(1) IN GENERAL.—To the extent that the  
8 group health plan (or health insurance issuer offer-  
9 ing health insurance coverage in connection with the  
10 plan) provides for any benefits consisting of emer-  
11 gency medical care (as defined in section  
12 503(b)(9)(I)), except for items or services specifi-  
13 cally excluded—

14 “(A) the plan or issuer shall provide bene-  
15 fits, without requiring preauthorization, for ap-  
16 propriate emergency medical screening exami-  
17 nations (within the capability of the emergency  
18 facility, including ancillary services routinely  
19 available to the emergency facility) to the extent  
20 that a prudent layperson, who possesses an av-  
21 erage knowledge of health and medicine, would  
22 determine such examinations to be necessary in  
23 order to determine whether emergency medical  
24 care (as so defined) is required, and

1 “(B) the plan or issuer shall provide bene-  
2 fits for additional emergency medical services  
3 following an emergency medical screening exam-  
4 ination (if determined necessary under subpara-  
5 graph (A)) to the extent that a prudent emer-  
6 gency medical professional would determine  
7 such additional emergency services to be nec-  
8 essary to avoid the consequences described in  
9 section 503(b)(9)(I).

10 “(2) UNIFORM COST-SHARING REQUIRED.—  
11 Nothing in this subsection shall be construed as pre-  
12 venting a group health plan or issuer from imposing  
13 any form of cost-sharing applicable to any partici-  
14 pant or beneficiary (including coinsurance, copay-  
15 ments, deductibles, and any other charges) in rela-  
16 tion to benefits described in paragraph (1), if such  
17 form of cost-sharing is uniformly applied under such  
18 plan, with respect to similarly situated participants  
19 and beneficiaries, to all benefits consisting of emer-  
20 gency medical care (as defined in section  
21 503(b)(9)(I)) provided to such similarly situated  
22 participants and beneficiaries under the plan.

23 “(c) PATIENT ACCESS TO OBSTETRIC AND GYNECO-  
24 LOGICAL CARE.



1           “(1) IN GENERAL.—In any case in which a  
2           group health plan (or a health insurance issuer of-  
3           fering health insurance coverage in connection with  
4           the plan)—

5                   “(A) provides benefits under the terms of  
6           the plan consisting of—

7                           “(i) routine gynecological care (such  
8                           as preventive women’s health examina-  
9                           tions), or

10                          “(ii) routine obstetric care (such as  
11                          routine pregnancy-related services),  
12                          provided by a participating physician who spe-  
13                          cializes in such care (or provides benefits con-  
14                          sisting of payment for such care), and

15                          “(B) the plan requires or provides for des-  
16                          ignation by a participant or beneficiary of a  
17                          participating primary care provider,

18           if the primary care provider designated by such a  
19           participant or beneficiary is not such a physician,  
20           then the plan (or issuer) shall meet the requirements  
21           of paragraph (2).

22           “(2) REQUIREMENTS.—A group health plan (or  
23           a health insurance issuer offering health insurance  
24           coverage in connection with the plan) meets the re-  
25           quirements of this paragraph, in connection with

1       benefits described in paragraph (1) consisting of  
2       care described in clause (i) or (ii) of paragraph  
3       (1)(A) (or consisting of payment therefor), if the  
4       plan (or issuer)—

5               “(A) does not require authorization or a  
6       referral by the primary care provider in order  
7       to obtain such benefits, and

8               “(B) treats the ordering of other routine  
9       care of the same type, by the participating phy-  
10      sician providing the care described in clause (i)  
11      or (ii) of paragraph (1)(A), as the authorization  
12      of the primary care provider with respect to  
13      such care.

14              “(3) CONSTRUCTION.—Nothing in paragraph  
15      (2)(B) shall waive any requirements of coverage re-  
16      lating to medical necessity or appropriateness with  
17      respect to coverage of gynecological or obstetric care  
18      so ordered.

19              “(d) PATIENT ACCESS TO PEDIATRIC CARE.—

20              “(1) IN GENERAL.—In any case in which a  
21      group health plan (or a health insurance issuer of-  
22      fering health insurance coverage in connection with  
23      the plan) provides benefits consisting of routine pe-  
24      diatric care provided by a participating physician  
25      who specializes in pediatrics (or consisting of pay-

1       ment for such care) and the plan requires or pro-  
 2       vides for designation by a participant or beneficiary  
 3       of a participating primary care provider, the plan (or  
 4       issuer) shall provide that such a participating physi-  
 5       cian may be designated, if available, by a parent or  
 6       guardian of any beneficiary under the plan is who  
 7       under 18 years of age, as the primary care provider  
 8       with respect to any such benefits.

9               “(2) CONSTRUCTION.—Nothing in paragraph  
 10       (1) shall waive any requirements of coverage relating  
 11       to medical necessity or appropriateness with respect  
 12       to coverage of pediatric care.

13       “(e) TREATMENT OF MULTIPLE COVERAGE OP-  
 14       TIONS.—In the case of a plan providing benefits under two  
 15       or more coverage options, the requirements of subsections  
 16       (c) and (d) shall apply separately with respect to each cov-  
 17       erage option.”.

18       (b) CONFORMING AMENDMENT.—The table of con-  
 19       tents in section 1 of such Act is amended by adding at  
 20       the end of the items relating to subpart B of part 7 of  
 21       subtitle B of title I of such Act the following new item:

      “Sec. 713. Patient access to unrestricted medical advice, emergency medical  
       care, obstetric and gynecological care, and pediatric care.”.

## 22   **SEC. 1002. EFFECTIVE DATE AND RELATED RULES.**

23       (a) IN GENERAL.—The amendments made by this  
 24       subtitle shall apply with respect to plan years beginning

1 on or after January 1 of the second calendar year follow-  
2 ing the date of the enactment of this Act, except that the  
3 Secretary of Labor may issue regulations before such date  
4 under such amendments. The Secretary shall first issue  
5 regulations necessary to carry out the amendments made  
6 by this section before the effective date thereof.

7 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
8 enforcement action shall be taken, pursuant to the amend-  
9 ments made by this subtitle, against a group health plan  
10 or health insurance issuer with respect to a violation of  
11 a requirement imposed by such amendments before the  
12 date of issuance of regulations issued in connection with  
13 such requirement, if the plan or issuer has sought to com-  
14 ply in good faith with such requirement.

15 (c) SPECIAL RULE FOR COLLECTIVE BARGAINING  
16 AGREEMENTS.—In the case of a group health plan main-  
17 tained pursuant to one or more collective bargaining  
18 agreements between employee representatives and one or  
19 more employers ratified before the date of the enactment  
20 of this Act, the provisions of subsections (b), (c), and (d)  
21 of section 713 of the Employee Retirement Income Secu-  
22 rity Act of 1974 (as added by this subtitle) shall not apply  
23 with respect to plan years beginning before the later of—

24 (1) the date on which the last of the collective  
25 bargaining agreements relating to the plan termi-

1 nates (determined without regard to any extension  
2 thereof agreed to after the date of the enactment of  
3 this Act), or

4 (2) January 1, 2001.

5 For purposes of this subsection, any plan amendment  
6 made pursuant to a collective bargaining agreement relat-  
7 ing to the plan which amends the plan solely to conform  
8 to any requirement added by this subtitle shall not be  
9 treated as a termination of such collective bargaining  
10 agreement.

11 (d) ASSURING COORDINATION.—The Secretary of  
12 Labor, the Secretary of the Treasury, and the Secretary  
13 of Health and Human Services shall ensure, through the  
14 execution of an interagency memorandum of understand-  
15 ing among such Secretaries, that—

16 (1) regulations, rulings, and interpretations  
17 issued by such Secretaries relating to the same mat-  
18 ter over which two or more such Secretaries have re-  
19 sponsibility under the provisions of this subtitle, sec-  
20 tion 2101, and subtitle A of title III (and the  
21 amendments made thereby) are administered so as  
22 to have the same effect at all times, and

23 (2) coordination of policies relating to enforcing  
24 the same requirements through such Secretaries in  
25 order to have a coordinated enforcement strategy

1       that avoids duplication of enforcement efforts and  
2       assigns priorities in enforcement.

3       (e) TREATMENT OF RELIGIOUS NONMEDICAL PRO-  
4       VIDERS.—

5           (1) IN GENERAL.—Nothing in this Act (or the  
6       amendments made thereby) shall be construed to—

7           (A) restrict or limit the right of group  
8       health plans, and of health insurance issuers of-  
9       fering health insurance coverage in connection  
10      with group health plans, to include as providers  
11      religious nonmedical providers,

12          (B) require such plans or issuers to—

13           (i) utilize medically based eligibility  
14      standards or criteria in deciding provider  
15      status of religious nonmedical providers,

16           (ii) use medical professionals or cri-  
17      teria to decide patient access to religious  
18      nonmedical providers,

19           (iii) utilize medical professionals or  
20      criteria in making decisions in internal or  
21      external appeals from decisions denying or  
22      limiting coverage for care by religious non-  
23      medical providers, or

24           (iv) compel a participant or bene-  
25      ficiary to undergo a medical examination

1 or test as a condition of receiving health  
 2 insurance coverage for treatment by a reli-  
 3 gious nonmedical provider, or

4 (C) require such plans or issuers to ex-  
 5 clude religious nonmedical providers because  
 6 they do not provide medical or other data other-  
 7 wise required, if such data is inconsistent with  
 8 the religious nonmedical treatment or nursing  
 9 care provided by the provider.

10 (2) RELIGIOUS NONMEDICAL PROVIDER.—For  
 11 purposes of this subsection, the term “religious non-  
 12 medical provider” means a provider who provides no  
 13 medical care but who provides only religious non-  
 14 medical treatment or religious nonmedical nursing  
 15 care.

## 16 **Subtitle B—Patient Access to** 17 **Information**

### 18 **SEC. 1101. PATIENT ACCESS TO INFORMATION REGARDING** 19 **PLAN COVERAGE, MANAGED CARE PROCE-** 20 **DURES, HEALTH CARE PROVIDERS, AND** 21 **QUALITY OF MEDICAL CARE.**

22 (a) IN GENERAL.—Part 1 of subtitle B of title I of  
 23 the Employee Retirement Income Security Act of 1974 is  
 24 amended—

1 (1) by redesignating section 111 as section 112;  
2 and

3 (2) by inserting after section 110 the following  
4 new section:

5 “DISCLOSURE BY GROUP HEALTH PLANS

6 “SEC. 111. (a) DISCLOSURE REQUIREMENT.—

7 “(1) GROUP HEALTH PLANS.—The adminis-  
8 trator of each group health plan shall take such ac-  
9 tions as are necessary to ensure that the summary  
10 plan description of the plan required under section  
11 102 (or each summary plan description in any case  
12 in which different summary plan descriptions are ap-  
13 propriate under part 1 for different options of cov-  
14 erage) contains, among any information otherwise  
15 required under this part, the information required  
16 under subsections (b), (c), (d), and (e)(2)(A).

17 “(2) HEALTH INSURANCE ISSUERS.—Each  
18 health insurance issuer offering health insurance  
19 coverage in connection with a group health plan  
20 shall provide the administrator on a timely basis  
21 with the information necessary to enable the admin-  
22 istrator to comply with the requirements of para-  
23 graph (1). To the extent that any such issuer pro-  
24 vides on a timely basis to plan participants and  
25 beneficiaries information otherwise required under  
26 this part to be included in the summary plan de-



1       scription, the requirements of sections 101(a)(1) and  
2       104(b) shall be deemed satisfied in the case of such  
3       plan with respect to such information.

4       “(b) PLAN BENEFITS.—The information required  
5       under subsection (a) includes the following:

6               “(1) COVERED ITEMS AND SERVICES.—

7                       “(A) CATEGORIZATION OF INCLUDED BEN-  
8                       EFITS.—A description of covered benefits, cat-  
9                       egorized by—

10                      “(i) types of items and services (in-  
11                      cluding any special disease management  
12                      program), and

13                      “(ii) types of health care professionals  
14                      providing such items and services.

15               “(B) EMERGENCY MEDICAL CARE.—A de-  
16       scription of the extent to which the plan covers  
17       emergency medical care (including the extent to  
18       which the plan provides for access to urgent  
19       care centers), and any definitions provided  
20       under the plan for the relevant plan terminol-  
21       ogy referring to such care.

22               “(C) PREVENTATIVE SERVICES.—A de-  
23       scription of the extent to which the plan pro-  
24       vides benefits for preventative services.

1           “(D) DRUG FORMULARIES.—A description  
2           of the extent to which covered benefits are de-  
3           termined by the use or application of a drug  
4           formulary and a summary of the process for de-  
5           termining what is included in such formulary.

6           “(E) COBRA CONTINUATION COV-  
7           ERAGE.—A description of the benefits available  
8           under the plan pursuant to part 6.

9           “(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-  
10          TIONS ON COVERED BENEFITS.—

11           “(A) CATEGORIZATION OF EXCLUDED  
12           BENEFITS.—A description of benefits specifi-  
13           cally excluded from coverage, categorized by  
14           types of items and services.

15           “(B) UTILIZATION REVIEW AND  
16           PREAUTHORIZATION REQUIREMENTS.—Whether  
17           coverage for medical care is limited or excluded  
18           on the basis of utilization review or  
19           preauthorization requirements.

20           “(C) LIFETIME, ANNUAL, OR OTHER PE-  
21           RIOD LIMITATIONS.—A description of the cir-  
22           cumstances under which, and the extent to  
23           which, coverage is subject to lifetime, annual, or  
24           other period limitations, categorized by types of  
25           benefits.

1           “(D) CUSTODIAL CARE.—A description of  
2           the circumstances under which, and the extent  
3           to which, the coverage of benefits for custodial  
4           care is limited or excluded, and a statement of  
5           the definition used by the plan for custodial  
6           care.

7           “(E) EXPERIMENTAL TREATMENTS.—  
8           Whether coverage for any medical care is lim-  
9           ited or excluded because it constitutes experi-  
10          mental treatment or technology, and any defini-  
11          tions provided under the plan for the relevant  
12          plan terminology referring to such limited or  
13          excluded care.

14          “(F) MEDICAL APPROPRIATENESS OR NE-  
15          CESSITY.—Whether coverage for medical care  
16          may be limited or excluded by reason of a fail-  
17          ure to meet the plan’s requirements for medical  
18          appropriateness or necessity, and any defini-  
19          tions provided under the plan for the relevant  
20          plan terminology referring to such limited or  
21          excluded care.

22          “(G) SECOND OR SUBSEQUENT OPIN-  
23          IONS.—A description of the circumstances  
24          under which, and the extent to which, coverage

1 for second or subsequent opinions is limited or  
2 excluded.

3 “(H) SPECIALTY CARE.—A description of  
4 the circumstances under which, and the extent  
5 to which, coverage of benefits for specialty care  
6 is conditioned on referral from a primary care  
7 provider.

8 “(I) CONTINUITY OF CARE.—A description  
9 of the circumstances under which, and the ex-  
10 tent to which, coverage of items and services  
11 provided by any health care professional is lim-  
12 ited or excluded by reason of the departure by  
13 the professional from any defined set of provid-  
14 ers.

15 “(J) RESTRICTIONS ON COVERAGE OF  
16 EMERGENCY SERVICES.—A description of the  
17 circumstances under which, and the extent to  
18 which, the plan, in covering emergency medical  
19 care furnished to a participant or beneficiary of  
20 the plan imposes any financial responsibility de-  
21 scribed in subsection (c) on participants or  
22 beneficiaries or limits or conditions benefits for  
23 such care subject to any other term or condition  
24 of such plan.

1       “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-  
2 ITIES.—The information required under subsection (a) in-  
3 cludes an explanation of—

4               “(1) a participant’s financial responsibility for  
5 payment of premiums, coinsurance, copayments,  
6 deductibles, and any other charges, and

7               “(2) the circumstances under which, and the  
8 extent to which, the participant’s financial respon-  
9 sibility described in paragraph (1) may vary, includ-  
10 ing any distinctions based on whether a health care  
11 provider from whom covered benefits are obtained is  
12 included in a defined set of providers.

13       “(d) DISPUTE RESOLUTION PROCEDURES.—The in-  
14 formation required under subsection (a) includes a de-  
15 scription of the processes adopted by the plan pursuant  
16 to section 503(b), including—

17               “(1) descriptions thereof relating specifically  
18 to—

19                       “(A) coverage decisions,

20                       “(B) internal review of coverage decisions,

21                       and

22                       “(C) any external review of coverage deci-  
23 sions, and

1           “(2) the procedures and time frames applicable  
2           to each step of the processes referred to in subpara-  
3           graphs (A), (B), and (C) of paragraph (1).

4           “(e) INFORMATION AVAILABLE ON REQUEST.—

5           “(1) ACCESS TO PLAN BENEFIT INFORMATION  
6           IN ELECTRONIC FORM.—

7           “(A) IN GENERAL.—In addition to the in-  
8           formation required to be provided under section  
9           104(b)(4), a group health plan (and a health  
10          insurance issuer offering health insurance cov-  
11          erage in connection with a group health plan)  
12          shall, upon written request (made not more fre-  
13          quently than annually), make available to par-  
14          ticipants and beneficiaries, in a generally recog-  
15          nized electronic format, the following informa-  
16          tion:

17                   “(i) the latest summary plan descrip-  
18                   tion, including the latest summary of ma-  
19                   terial modifications; and

20                   “(ii) the actual plan provisions setting  
21                   forth the benefits available under the plan  
22                   to the extent such information relates to the  
23                   coverage options under the plan available to the  
24                   participant or beneficiary. A reasonable charge  
25                   may be made to cover the cost of providing

1 such information in such generally recognized  
2 electronic format. The Secretary may by regula-  
3 tion prescribe a maximum amount which will  
4 constitute a reasonable charge under the pre-  
5 ceding sentence.

6 “(B) ALTERNATIVE ACCESS.—The require-  
7 ments of this paragraph may be met by making  
8 such information generally available (rather  
9 than upon request) on the Internet or on a pro-  
10 prietary computer network in a format which is  
11 readily accessible to participants and bene-  
12 ficiaries.

13 “(2) ADDITIONAL INFORMATION TO BE PRO-  
14 VIDED ON REQUEST.—

15 “(A) INCLUSION IN SUMMARY PLAN DE-  
16SCRIPTION OF SUMMARY OF ADDITIONAL IN-  
17FORMATION.—The information required under  
18 subsection (a) includes a summary description  
19 of the types of information required by this  
20 subsection to be made available to participants  
21 and beneficiaries on request.

22 “(B) INFORMATION REQUIRED FROM  
23 PLANS AND ISSUERS ON REQUEST.—In addition  
24 to information required to be included in sum-  
25 mary plan descriptions under this subsection, a

1 group health plan (and a health insurance  
2 issuer offering health insurance coverage in  
3 connection with a group health plan) shall pro-  
4 vide the following information to a participant  
5 or beneficiary on request:

6 “(i) NETWORK CHARACTERISTICS.—If  
7 the plan (or issuer) utilizes a defined set of  
8 providers under contract with the plan (or  
9 issuer), a detailed list of the names of such  
10 providers and their geographic location, set  
11 forth separately with respect to primary  
12 care providers and with respect to special-  
13 ists.

14 “(ii) CARE MANAGEMENT INFORMA-  
15 TION.—A description of the circumstances  
16 under which, and the extent to which, the  
17 plan has special disease management pro-  
18 grams or programs for persons with dis-  
19 abilities, indicating whether these pro-  
20 grams are voluntary or mandatory and  
21 whether a significant benefit differential  
22 results from participation in such pro-  
23 grams.

24 “(iii) INCLUSION OF DRUGS AND  
25 BIOLOGICALS IN FORMULARIES.—A state-



1           ment of whether a specific drug or biologi-  
2           cal is included in a formulary used to de-  
3           termine benefits under the plan and a de-  
4           scription of the procedures for considering  
5           requests for any patient-specific waivers.

6           “(iv) PROCEDURES FOR DETERMINING  
7           EXCLUSIONS BASED ON MEDICAL NECES-  
8           SITY OR EXPERIMENTAL TREATMENTS.—

9           Upon receipt by the participant or bene-  
10          ficiary of any notification of an adverse  
11          coverage decision based on a determination  
12          relating to medical necessity or an experi-  
13          mental treatment or technology, a descrip-  
14          tion of the procedures and medically-based  
15          criteria used in such decision.

16          “(v) PREAUTHORIZATION AND UTILI-  
17          ZATION REVIEW PROCEDURES.—Upon re-  
18          ceipt by the participant or beneficiary of  
19          any notification of an adverse coverage de-  
20          cision, a description of the basis on which  
21          any preauthorization requirement or any  
22          utilization review requirement has resulted  
23          in such decision.

24          “(vi) ACCREDITATION STATUS OF  
25          HEALTH INSURANCE ISSUERS AND SERV-

1 ICE PROVIDERS.—A description of the ac-  
2 creditation and licencing status (if any) of  
3 each health insurance issuer offering  
4 health insurance coverage in connection  
5 with the plan and of any utilization review  
6 organization utilized by the issuer or the  
7 plan, together with the name and address  
8 of the accrediting or licencing authority.

9 “(vii) MEASURES OF ENROLLEE SAT-  
10 ISFACTION.—The latest information (if  
11 any) maintained by the plan, or by any  
12 health insurance issuer offering health in-  
13 surance coverage in connection with the  
14 plan, relating to enrollee satisfaction.

15 “(viii) QUALITY PERFORMANCE MEAS-  
16 URES.—The latest information (if any)  
17 maintained by the plan, or by any health  
18 insurance issuer offering health insurance  
19 coverage in connection with the plan, relat-  
20 ing to quality of performance of the deliv-  
21 ery of medical care with respect to cov-  
22 erage options offered under the plan and  
23 of health care professionals and facilities  
24 providing medical care under the plan.

1           “(C) INFORMATION REQUIRED FROM  
2 HEALTH CARE PROFESSIONALS ON REQUEST.—  
3 Any health care professional treating a partici-  
4 pant or beneficiary under a group health plan  
5 shall provide to the participant or beneficiary,  
6 on request, a description of his or her profes-  
7 sional qualifications (including board certifi-  
8 cation status, licensing status, and accreditation  
9 status, if any), privileges, and experience and a  
10 general description by category (including sal-  
11 ary, fee-for-service, capitation, and such other  
12 categories as may be specified in regulations of  
13 the Secretary) of the applicable method by  
14 which such professional is compensated in con-  
15 nection with the provision of such medical care.

16           “(D) INFORMATION REQUIRED FROM  
17 HEALTH CARE FACILITIES ON REQUEST.—Any  
18 health care facility from which a participant or  
19 beneficiary has sought treatment under a group  
20 health plan shall provide to the participant or  
21 beneficiary, on request, a description of the fa-  
22 cility’s corporate form or other organizational  
23 form and all forms of licensing and accredita-  
24 tion status (if any) assigned to the facility by  
25 standard-setting organizations.

1       “(f) ACCESS TO INFORMATION RELEVANT TO THE  
2 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR  
3 BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to  
4 information otherwise required to be made available under  
5 this section, a group health plan (and a health insurance  
6 issuer offering health insurance coverage in connection  
7 with a group health plan) shall, upon written request  
8 (made not more frequently than annually), make available  
9 to a participant in connection with a period of enrollment  
10 the summary plan description for any coverage option  
11 under the plan under which the participant is eligible to  
12 enroll and any information described in clauses (i), (ii),  
13 (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

14       “(g) ADVANCE NOTICE OF CHANGES IN DRUG  
15 FORMULARIES.—Not later than 30 days before the effec-  
16 tive of date of any exclusion of a specific drug or biological  
17 from any drug formulary under the plan that is used in  
18 the treatment of a chronic illness or disease, the plan shall  
19 take such actions as are necessary to reasonably ensure  
20 that plan participants are informed of such exclusion. The  
21 requirements of this subsection may be satisfied—

22               “(1) by inclusion of information in publications  
23       broadly distributed by plan sponsors, employers, or  
24       employee organizations,

1           “(2) by electronic means of communication (in-  
2           cluding the Internet or proprietary computer net-  
3           works in a format which is readily accessible to par-  
4           ticipants),

5           “(3) by timely informing participants who,  
6           under an ongoing program maintained under the  
7           plan, have submitted their names for such notifica-  
8           tion, or

9           “(4) by any other reasonable means of timely  
10          informing plan participants.

11         “(h) DEFINITIONS.—For purposes of this section—

12                 “(1) GROUP HEALTH PLAN.—The term ‘group  
13                 health plan’ has the meaning provided such term  
14                 under section 503(b)(6).

15                 “(2) MEDICAL CARE.—The term ‘medical care’  
16                 has the meaning provided such term under section  
17                 733(a)(2).

18                 “(3) HEALTH INSURANCE COVERAGE.—The  
19                 term ‘health insurance coverage’ has the meaning  
20                 provided such term under section 733(b)(1).

21                 “(4) HEALTH INSURANCE ISSUER.—The term  
22                 ‘health insurance issuer’ has the meaning provided  
23                 such term under section 733(b)(2).”.

24         (b) CONFORMING AMENDMENTS.—

1           (1) Section 102(b) of such Act (29 U.S.C.  
2       1022(b)) is amended—

3           (A) by striking “section 733(a)(1)” each  
4       place it appears and inserting “section  
5       503(b)(6)”;

6           (B) by inserting before the period at the  
7       end the following: “; and, in the case of a  
8       group health plan (as defined in section  
9       111(h)(1)), the information required to be in-  
10      cluded under section 111(a)”.

11          (2) The table of contents in section 1 of such  
12      Act is amended by striking the item relating to sec-  
13      tion 111 and inserting the following new items:

“Sec. 111. Disclosure by group health plans.  
“Sec. 112. Repeal and effective date.”.

14      **SEC. 1102. EFFECTIVE DATE AND RELATED RULES.**

15          (a) IN GENERAL.—The amendments made by this  
16      subtitle shall apply with respect to plan years beginning  
17      on or after January 1 of the second calendar year follow-  
18      ing the date of the enactment of this Act. The Secretary  
19      shall first issue all regulations necessary to carry out the  
20      amendments made by this subtitle before such date.

21          (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
22      enforcement action shall be taken, pursuant to the amend-  
23      ments made by this subtitle, against a group health plan  
24      or health insurance issuer with respect to a violation of

1 a requirement imposed by such amendments before the  
2 date of issuance of final regulations issued in connection  
3 with such requirement, if the plan or issuer has sought  
4 to comply in good faith with such requirement.

5 (c) ASSURING COORDINATION.—The Secretary of  
6 Labor, the Secretary of Health and Human Services, and  
7 the Secretary of the Treasury shall ensure, through the  
8 execution of an interagency memorandum of understand-  
9 ing among such Secretaries, that—

10 (1) regulations, rulings, and interpretations  
11 issued by such Secretaries relating to the same mat-  
12 ter over which two or more such Secretaries have re-  
13 sponsibility under the provisions of this subtitle, sub-  
14 title B of title II, and subtitle B of title III (and the  
15 amendments made thereby) are administered so as  
16 to have the same effect at all times, and

17 (2) coordination of policies relating to enforcing  
18 the same requirements through such Secretaries in  
19 order to have a coordinated enforcement strategy  
20 that avoids duplication of enforcement efforts and  
21 assigns priorities in enforcement.

1 **Subtitle C—New Procedures and**  
2 **Access to Courts for Grievances**  
3 **Arising Under Group Health**  
4 **Plans**

5 **SEC. 1201. SPECIAL RULES FOR GROUP HEALTH PLANS.**

6 (a) IN GENERAL.—Section 503 of the Employee Re-  
7 tirement Income Security Act of 1974 (29 U.S.C. 1133)  
8 is amended—

9 (1) by inserting “(a) IN GENERAL.—” after  
10 “SEC. 503.”;

11 (2) by inserting “(other than a group health  
12 plan)” after “employee benefit plan”; and

13 (3) by adding at the end the following new sub-  
14 section:

15 “(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

16 “(1) COVERAGE DETERMINATIONS.—Every  
17 group health plan shall—

18 “(A) provide adequate notice in writing in  
19 accordance with this subsection to any partici-  
20 pant or beneficiary of any adverse coverage de-  
21 cision with respect to benefits of such partici-  
22 pant or beneficiary under the plan, setting forth  
23 the specific reasons for such coverage decision  
24 and any rights of review provided under the



1 plan, written in a manner calculated to be un-  
2 derstood by the participant,

3 “(B) provide such notice in writing also to  
4 any treating medical care provider of such par-  
5 ticipant or beneficiary, if such provider has  
6 claimed reimbursement for any item or service  
7 involved in such coverage decision, or if a claim  
8 submitted by the provider initiated the proceed-  
9 ings leading to such decision,

10 “(C) afford a reasonable opportunity to  
11 any participant or beneficiary who is in receipt  
12 of the notice of such adverse coverage decision,  
13 and who files a written request for review of the  
14 initial coverage decision within 180 days after  
15 receipt of the notice of the initial decision, for  
16 a full and fair de novo review of the decision by  
17 an appropriate named fiduciary who did not  
18 make the initial decision, and

19 “(D) meet the additional requirements of  
20 this subsection.

21 “(2) TIME LIMITS FOR MAKING INITIAL COV-  
22 ERAGE DECISIONS FOR BENEFITS AND COMPLETING  
23 INTERNAL APPEALS.—

24 “(A) TIME LIMITS FOR DECIDING RE-  
25 QUESTS FOR BENEFIT PAYMENTS, REQUESTS

1           FOR ADVANCE DETERMINATION OF COVERAGE,  
2           AND REQUESTS FOR REQUIRED DETERMINA-  
3           TION OF MEDICAL NECESSITY.—Except as pro-  
4           vided in subparagraph (B)—

5                   “(i) INITIAL DECISIONS.—If a request  
6                   for benefit payments, a request for advance  
7                   determination of coverage, or a request for  
8                   required determination of medical necessity  
9                   is submitted to a group health plan in such  
10                  reasonable form as may be required under  
11                  the plan, the plan shall issue in writing an  
12                  initial coverage decision on the request be-  
13                  fore the end of the initial decision period  
14                  under paragraph (9)(J) following the filing  
15                  completion date. Failure to issue a cov-  
16                  erage decision on such a request before the  
17                  end of the period required under this  
18                  clause shall be treated as an adverse cov-  
19                  erage decision for purposes of internal re-  
20                  view under clause (ii).

21                  “(ii) INTERNAL REVIEWS OF INITIAL  
22                  DENIALS.—Upon the written request of a  
23                  participant or beneficiary for review of an  
24                  initial adverse coverage decision under  
25                  clause (i), a review by an appropriate

1            named fiduciary (subject to paragraph (3))  
2            of the initial coverage decision shall be  
3            completed, including issuance by the plan  
4            of a written decision affirming, reversing,  
5            or modifying the initial coverage decision,  
6            setting forth the grounds for such decision,  
7            before the end of the internal review period  
8            following the review filing date. Such deci-  
9            sion shall be treated as the final decision  
10          of the plan, subject to any applicable re-  
11          consideration under paragraph (4). Failure  
12          to issue before the end of such period such  
13          a written decision requested under this  
14          clause shall be treated as a final decision  
15          affirming the initial coverage decision, sub-  
16          ject to any applicable reconsideration  
17          under paragraph (4).

18            “(B) TIME LIMITS FOR MAKING COVERAGE  
19            DECISIONS RELATING TO URGENT AND EMER-  
20            GENCY MEDICAL CARE AND FOR COMPLETING  
21            INTERNAL APPEALS.—

22            “(i) INITIAL DECISIONS.—A group  
23            health plan shall issue in writing an initial  
24            coverage decision on any request for expe-  
25            dited advance determination of coverage or

1 for expedited required determination of  
2 medical necessity submitted, in such rea-  
3 sonable form as may be required under the  
4 plan—

5 “(I) before the end of the urgent  
6 decision period under paragraph  
7 (9)(L), in cases involving urgent med-  
8 ical care but not involving emergency  
9 medical care, or

10 “(II) before the end of the emer-  
11 gency decision period under para-  
12 graph (9)(M), in cases involving emer-  
13 gency medical care,  
14 following the filing completion date. Fail-  
15 ure to approve or deny such a request be-  
16 fore the end of the applicable decision pe-  
17 riod shall be treated as a denial of the re-  
18 quest for purposes of internal review under  
19 clause (ii).

20 “(ii) INTERNAL REVIEWS OF INITIAL  
21 DENIALS.—Upon the written request of a  
22 participant or beneficiary for review of an  
23 initial adverse coverage decision under  
24 clause (i), a review by an appropriate  
25 named fiduciary (subject to paragraph (3))

1 of the initial coverage decision shall be  
2 completed, including issuance by the plan  
3 of a written decision affirming, reversing,  
4 or modifying the initial coverage decision,  
5 setting forth the grounds for the deci-  
6 sion—

7 “(I) before the end of the urgent  
8 decision period under paragraph  
9 (9)(L), in cases involving urgent med-  
10 ical care but not involving emergency  
11 medical care, or

12 “(II) before the end of the emer-  
13 gency decision period under para-  
14 graph (9)(M), in cases involving emer-  
15 gency medical care,

16 following the review filing date. Such deci-  
17 sion shall be treated as the final decision  
18 of the plan, subject to any applicable re-  
19 consideration under paragraph (4). Failure  
20 to issue before the end of the applicable  
21 decision period such a written decision re-  
22 quested under this clause shall be treated  
23 as a final decision affirming the initial cov-  
24 erage decision, subject to any applicable re-  
25 consideration under paragraph (4).

1           “(3) PHYSICIANS MUST REVIEW INITIAL COV-  
2           ERAGE DECISIONS INVOLVING MEDICAL APPRO-  
3           PRIATENESS OR NECESSITY OR EXPERIMENTAL  
4           TREATMENT.—If an initial coverage decision under  
5           paragraph (2)(A)(i) or (2)(B)(i) is based on a deter-  
6           mination that provision of a particular item or serv-  
7           ice is excluded from coverage under the terms of the  
8           plan because the provision of such item or service  
9           does not meet the plan’s requirements for medical  
10          appropriateness or necessity or would constitute ex-  
11          perimental treatment or technology, the review  
12          under paragraph (2)(A)(ii) or (2)(B)(ii), to the ex-  
13          tent that it relates to medical appropriateness or ne-  
14          cessity or to experimental treatment or technology,  
15          shall be conducted by a physician who is selected to  
16          serve as an appropriate named fiduciary under the  
17          plan and who did not make the initial denial.

18           “(4) ELECTIVE EXTERNAL REVIEW BY INDE-  
19           PENDENT MEDICAL EXPERT AND RECONSIDERATION  
20           OF INITIAL REVIEW DECISION.—

21           “(A) IN GENERAL.—The requirements of  
22           subparagraphs (B), (C) and (D) shall apply—

23                   “(i) in the case of any failure to time-  
24                   ly issue a coverage decision upon internal  
25                   review which is deemed to be an adverse

coverage decision under paragraph (2)(A)(ii) or (2)(B)(ii) (thereby failing to constitute a coverage decision for which specific reasons have been set forth as required under paragraph (1)(A)), and

“(ii) in the case of any adverse coverage decision which is not reversed upon a review conducted pursuant to paragraph (1)(C) (including any review pursuant to paragraph (2)(A)(ii) or (2)(B)(ii)), if such coverage decision is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service—

“(I) does not meet the plan’s requirements for medical appropriateness or necessity, or

“(II) would constitute experimental treatment or technology.

“(B) LIMITS ON ALLOWABLE ADVANCE PAYMENTS.—The review under this paragraph in connection with an adverse coverage decision shall be available subject to any requirement of the plan (unless waived by the plan for financial

1 or other reasons) for payment in advance to the  
2 plan by the participant or beneficiary seeking  
3 review of an amount not to exceed the greater  
4 of—

5 “(i) the lesser of \$100 or 10 percent  
6 of the cost of the medical care involved in  
7 the decision, or

8 “(ii) \$25,  
9 with each such dollar amount subject to com-  
10 pounded annual adjustments in the same man-  
11 ner and to the same extent as apply under sec-  
12 tion 215(i) of the Social Security Act, except  
13 that, for any calendar year, such amount as so  
14 adjusted shall be deemed, solely for such cal-  
15 endar year, to be equal to such amount rounded  
16 to the nearest \$10. No such payment may be  
17 required in the case of any participant or bene-  
18 ficiary whose enrollment under the plan is paid  
19 for, in whole or in part, under a State plan  
20 under title XIX or XXI of the Social Security  
21 Act. Any such advance payment shall be subject  
22 to reimbursement if the recommendation of the  
23 independent medical expert or experts under  
24 subparagraph (C)(iii) is to reverse or modify  
25 the coverage decision.



1           “(C) RECONSIDERATION OF INITIAL RE-  
2           VIEW DECISION.—In any case in which a partic-  
3           ipant or beneficiary who has received an ad-  
4           verse decision of the plan upon initial review of  
5           the coverage decision and who has not com-  
6           menced review of the initial coverage decision  
7           under section 502 makes a request in writing,  
8           within 30 days after the date of such review de-  
9           cision, for reconsideration of such review deci-  
10          sion, the terms of the plan shall provide for a  
11          procedure for such reconsideration under  
12          which—

13                 “(i) one or more independent medical  
14                 experts will be selected in accordance with  
15                 subparagraph (E) to review the coverage  
16                 decision described in subparagraph (A) to  
17                 determine whether such decision was in ac-  
18                 cordance with the terms of the plan and  
19                 this title,

20                 “(ii) the record for review (including a  
21                 specification of the terms of the plan and  
22                 other criteria serving as the basis for the  
23                 initial review decision) will be presented to  
24                 such expert or experts and maintained in

1 a manner which will ensure confidentiality  
2 of such record,

3 “(iii) such expert or experts will re-  
4 port in writing to the plan their rec-  
5 ommendation, based on the determination  
6 made under clause (i), as to whether such  
7 coverage decision should be affirmed, modi-  
8 fied, or reversed, setting forth the grounds  
9 (including the clinical basis) for the rec-  
10 ommendation, and

11 “(iv) a physician who did not make  
12 the initial review decision will reconsider  
13 the initial review decision to determine  
14 whether such decision was in accordance  
15 with the terms of the plan and this title  
16 and will issue a written decision affirming,  
17 modifying, or reversing the initial review  
18 decision, taking into account any rec-  
19 ommendations reported to the plan pursu-  
20 ant to clause (iii), and setting forth the  
21 grounds for the decision.

22 “(D) TIME LIMITS FOR RECONSIDER-  
23 ATION.—Any review under this paragraph shall  
24 be completed before the end of the reconsider-  
25 ation period (as defined in paragraph (9)(O))

1 following the review filing date in connection  
2 with such review. The decision under this para-  
3 graph affirming, reversing, or modifying the ini-  
4 tial review decision of the plan shall be the final  
5 decision of the plan. Failure to issue a written  
6 decision before the end of the reconsideration  
7 period in any reconsideration requested under  
8 this paragraph shall be treated as a final deci-  
9 sion affirming the initial review decision of the  
10 plan.

11 “(E) INDEPENDENT MEDICAL EXPERTS.—

12 “(i) IN GENERAL.—For purposes of  
13 this paragraph, the term ‘independent  
14 medical expert’ means, in connection with  
15 any coverage decision by a group health  
16 plan, a professional—

17 “(I) who is a physician or, if ap-  
18 propriate, another medical profes-  
19 sional,

20 “(II) who has appropriate cre-  
21 dentials and has attained recognized  
22 expertise in the applicable medical  
23 field,

1 “(III) who was not involved in  
2 the initial decision or any earlier re-  
3 view thereof, and

4 “(IV) who is selected in accord-  
5 ance with clause (ii) and meets the re-  
6 quirements of clause (iii).

7 “(ii) SELECTION OF MEDICAL EX-  
8 PERTS.—An independent medical expert is  
9 selected in accordance with this clause if—

10 “(I) the expert is selected by an  
11 intermediary which itself meets the re-  
12 quirements of clause (iii), by means of  
13 a method which ensures that the iden-  
14 tity of the expert is not disclosed to  
15 the plan, any health insurance issuer  
16 offering health insurance coverage to  
17 the aggrieved participant or bene-  
18 ficiary in connection with the plan,  
19 and the aggrieved participant or bene-  
20 ficiary under the plan, and the identi-  
21 ties of the plan, the issuer, and the  
22 aggrieved participant or beneficiary  
23 are not disclosed to the expert,

24 “(II) the expert is selected, by an  
25 appropriately credentialed panel of

1 physicians meeting the requirements  
2 of clause (iii) established by a fully  
3 accredited teaching hospital meeting  
4 such requirements,

5 “(III) the expert is selected by an  
6 organization described in section  
7 1152(1)(A) of the Social Security Act  
8 which meets the requirements of  
9 clause (iii),

10 “(IV) the expert is selected by an  
11 external review organization which  
12 meets the requirements of clause (iii)  
13 and is accredited by a private stand-  
14 ard-setting organization meeting such  
15 requirements and recognized as such  
16 by the Secretary, or

17 “(V) the expert is selected, by an  
18 intermediary or otherwise, in a man-  
19 ner that is, under regulations issued  
20 pursuant to negotiated rulemaking,  
21 sufficient to ensure the expert’s inde-  
22 pendence,

23 and the method of selection is devised to  
24 reasonably ensure that the expert selected

1 meets the independence requirements of  
2 clause (iii).

3 “(iii) INDEPENDENCE REQUIRE-  
4 MENTS.—An independent medical expert  
5 or another entity described in clause (ii)  
6 meets the independence requirements of  
7 this clause if—

8 “(I) the expert or entity is not  
9 affiliated with any related party,

10 “(II) any compensation received  
11 by such expert or entity in connection  
12 with the external review is reasonable  
13 and not contingent on any decision  
14 rendered by the expert or entity,

15 “(III) under the terms of the  
16 plan and any health insurance cov-  
17 erage offered in connection with the  
18 plan, the plan and the issuer (if any)  
19 have no recourse against the expert or  
20 entity in connection with the external  
21 review, and

22 “(IV) the expert or entity does  
23 not otherwise have a conflict of inter-  
24 est with a related party as determined

1 under any regulations which the Sec-  
2 retary may prescribe.

3 “(iv) RELATED PARTY.—For purposes  
4 of clause (ii)(I), the term ‘related party’  
5 means—

6 “(I) the plan or any health insur-  
7 ance issuer offering health insurance  
8 coverage in connection with the plan  
9 (or any officer, director, or manage-  
10 ment employee of such plan or issuer),

11 “(II) the physician or other medi-  
12 cal care provider that provided the  
13 medical care involved in the coverage  
14 decision,

15 “(III) the institution at which  
16 the medical care involved in the cov-  
17 erage decision is provided,

18 “(IV) the manufacturer of any  
19 drug or other item that was included  
20 in the medical care involved in the  
21 coverage decision, or

22 “(V) any other party determined  
23 under any regulations which the Sec-  
24 retary may prescribe to have a sub-

1                   stantial interest in the coverage deci-  
2                   sion .

3                   “(v) AFFILIATED.—For purposes of  
4                   clause (iii)(I), the term ‘affiliated’ means,  
5                   in connection with any entity, having a fa-  
6                   milial, financial, or professional relation-  
7                   ship with, or interest in, such entity.

8                   “(F) INAPPLICABILITY WITH RESPECT TO  
9                   ITEMS AND SERVICES SPECIFICALLY EXCLUDED  
10                  FROM COVERAGE.—An adverse coverage deci-  
11                  sion based on a determination that an item or  
12                  service is excluded from coverage under the  
13                  terms of the plan shall not be subject to review  
14                  under this paragraph, unless such determina-  
15                  tion is found in such decision to be based solely  
16                  on the fact that the item or service—

17                  “(i) does not meet the plan’s require-  
18                  ments for medical appropriateness or ne-  
19                  cessity, or

20                  “(ii) would constitute experimental  
21                  treatment or technology (as defined under  
22                  the plan).

23                  “(5) PERMITTED ALTERNATIVES TO REQUIRED  
24                  INTERNAL REVIEW.—



1           “(A) IN GENERAL.—A group health plan  
2           shall not be treated as failing to meet the re-  
3           quirements under paragraphs (2)(A)(ii) and  
4           (2)(B)(ii) relating to review of initial coverage  
5           decisions for benefits, if—

6                   “(i) in lieu of the procedures relating  
7                   to review under paragraphs (2)(A)(ii) and  
8                   (2)(B)(ii) and in accordance with such reg-  
9                   ulations (if any) as may be prescribed by  
10                  the Secretary—

11                       “(I) the aggrieved participant or  
12                       beneficiary elects in the request for  
13                       the review an alternative dispute reso-  
14                       lution procedure which is available  
15                       under the plan with respect to simi-  
16                       larly situated participants and bene-  
17                       ficiaries, or

18                       “(II) in the case of any such plan  
19                       or portion thereof which is established  
20                       and maintained pursuant to a bona  
21                       fide collective bargaining agreement,  
22                       the plan provides for a procedure by  
23                       which such disputes are resolved by  
24                       means of any alternative dispute reso-  
25                       lution procedure,

1 “(ii) the time limits not exceeding the  
2 time limits otherwise applicable under  
3 paragraphs (2)(A)(ii) and (2)(B)(ii) are in-  
4 corporated in such alternative dispute reso-  
5 lution procedure,

6 “(iii) any applicable requirement for  
7 review by a physician under paragraph (3),  
8 unless waived by the participant or bene-  
9 ficiary (in a manner consistent with such  
10 regulations as the Secretary may prescribe  
11 to ensure equitable procedures), is incor-  
12 porated in such alternative dispute resolu-  
13 tion procedure, and

14 “(iv) the plan meets the additional re-  
15 quirements of subparagraph (B).

16 In any case in which a procedure described in  
17 subclause (I) or (II) of clause (i) is utilized and  
18 an alternative dispute resolution procedure is  
19 voluntarily elected by the aggrieved participant  
20 or beneficiary, the plan may require or allow (in  
21 a manner consistent with such regulations as  
22 the Secretary may prescribe to ensure equitable  
23 procedures) the aggrieved participant or bene-  
24 ficiary to waive review of the coverage decision  
25 under paragraph (3), to waive further review of

1 the coverage decision under paragraph (4) or  
2 section 502, and to elect an alternative means  
3 of external review (other than review under  
4 paragraph (4)).

5 “(B) ADDITIONAL REQUIREMENTS.—The  
6 requirements of this subparagraph are met if  
7 the means of resolution of dispute allow for  
8 adequate presentation by the aggrieved partici-  
9 pant or beneficiary of scientific and medical evi-  
10 dence supporting the position of such partici-  
11 pant or beneficiary.

12 “(6) PERMITTED ALTERNATIVES TO REQUIRED  
13 EXTERNAL REVIEW.—A group health plan shall not  
14 be treated as failing to meet the requirements of this  
15 subsection in connection with review of coverage de-  
16 cisions under paragraph (4) if the aggrieved partici-  
17 pant or beneficiary elects to utilize a procedure in  
18 connection with such review which is made generally  
19 available under the plan (in a manner consistent  
20 with such regulations as the Secretary may prescribe  
21 to ensure equitable procedures) under which—

22 “(A) the plan agrees in advance of the rec-  
23 ommendations of the independent medical ex-  
24 pert or experts under paragraph (4)(C)(iii) to

1           render a final decision in accordance with such  
2           recommendations, and

3                   “(B) the participant or beneficiary waives  
4           in advance any right to review of the final deci-  
5           sion under section 502.

6                   “(7) SPECIAL RULE FOR ACCESS TO SPECIALTY  
7           CARE.— In the case of a request for advance deter-  
8           mination of coverage consisting of a request by a  
9           physician for a determination of coverage of the  
10          services of a specialist with respect to any condition,  
11          if coverage of the services of such specialist for such  
12          condition is otherwise provided under the plan, the  
13          initial coverage decision referred to in subparagraph  
14          (A)(i) or (B)(i) of paragraph (2) shall be issued  
15          within the specialty decision period. For purposes of  
16          this paragraph, the term ‘specialist’ means, with re-  
17          spect to a condition, a physician who has a high level  
18          of expertise through appropriate training and experi-  
19          ence (including, in the case of a child, appropriate  
20          pediatric expertise) to treat the condition.

21                   “(8) GROUP HEALTH PLAN DEFINED.—For  
22          purposes of this section—

23                           “(A) IN GENERAL.—The term ‘group  
24          health plan’ shall have the meaning provided in  
25          section 733(a).

1 “(B) TREATMENT OF PARTNERSHIPS.—

2 The provisions of paragraphs (1), (2), and (3)  
3 of section 732(d) shall apply.

4 “(9) OTHER DEFINITIONS.—For purposes of  
5 this subsection—

6 “(A) REQUEST FOR BENEFIT PAY-  
7 MENTS.—The term ‘request for benefit pay-  
8 ments’ means a request, for payment of benefits  
9 by a group health plan for medical care, which  
10 is made by or on behalf of a participant or ben-  
11 eficiary after such medical care has been pro-  
12 vided.

13 “(B) REQUIRED DETERMINATION OF MED-  
14 ICAL NECESSITY.—The term ‘required deter-  
15 mination of medical necessity’ means a deter-  
16 mination required under a group health plan  
17 solely that proposed medical care meets, under  
18 the facts and circumstances at the time of the  
19 determination, the plan’s requirements for med-  
20 ical appropriateness or necessity (which may be  
21 subject to exceptions under the plan for fraud  
22 or misrepresentation), irrespective of whether  
23 the proposed medical care otherwise meets  
24 other terms and conditions of coverage, but  
25 only if such determination does not constitute

1 an advance determination of coverage (as de-  
2 fined in subparagraph (C)).

3 “(C) ADVANCE DETERMINATION OF COV-  
4 ERAGE.—The term ‘advance determination of  
5 coverage’ means a determination under a group  
6 health plan that proposed medical care meets,  
7 under the facts and circumstances at the time  
8 of the determination, the plan’s terms and con-  
9 ditions of coverage (which may be subject to ex-  
10 ceptions under the plan for fraud or misrepre-  
11 sentation).

12 “(D) REQUEST FOR ADVANCE DETERMINA-  
13 TION OF COVERAGE.—The term ‘request for ad-  
14 vance determination of coverage’ means a re-  
15 quest for an advance determination of coverage  
16 of medical care which is made by or on behalf  
17 of a participant or beneficiary before such medi-  
18 cal care is provided.

19 “(E) REQUEST FOR EXPEDITED ADVANCE  
20 DETERMINATION OF COVERAGE.—The term ‘re-  
21 quest for expedited advance determination of  
22 coverage’ means a request for advance deter-  
23 mination of coverage, in any case in which the  
24 proposed medical care constitutes urgent medi-  
25 cal care or emergency medical care.

1           “(F) REQUEST FOR REQUIRED DETER-  
2 MINATION OF MEDICAL NECESSITY.—The term  
3 ‘request for required determination of medical  
4 necessity’ means a request for a required deter-  
5 mination of medical necessity for medical care  
6 which is made by or on behalf of a participant  
7 or beneficiary before the medical care is pro-  
8 vided.

9           “(G) REQUEST FOR EXPEDITED REQUIRED  
10 DETERMINATION OF MEDICAL NECESSITY.—  
11 The term ‘request for expedited required deter-  
12 mination of medical necessity’ means a request  
13 for required determination of medical necessity  
14 in any case in which the proposed medical care  
15 constitutes urgent medical care or emergency  
16 medical care.

17           “(H) URGENT MEDICAL CARE.—The term  
18 ‘urgent medical care’ means medical care in any  
19 case in which an appropriate physician has cer-  
20 tified in writing (or as otherwise provided in  
21 regulations of the Secretary) that failure to pro-  
22 vide the participant or beneficiary with such  
23 medical care within 45 days can reasonably be  
24 expected to result in either—

1 “(i) the imminent death of the partici-  
2 pant or beneficiary, or

3 “(ii) the immediate, serious, and irre-  
4 versible deterioration of the health of the  
5 participant or beneficiary which will sig-  
6 nificantly increase the likelihood of death  
7 of, or irreparable harm to, the participant  
8 or beneficiary.

9 “(I) EMERGENCY MEDICAL CARE.—The  
10 term ‘emergency medical care’ means medical  
11 care in any case in which an appropriate physi-  
12 cian has certified in writing (or as otherwise  
13 provided in regulations of the Secretary)—

14 “(i) that failure to immediately pro-  
15 vide the care to the participant or bene-  
16 ficiary could reasonably be expected to re-  
17 sult in—

18 “(I) placing the health of such  
19 participant or beneficiary (or, with re-  
20 spect to such a participant or bene-  
21 ficiary who is a pregnant woman, the  
22 health of the woman or her unborn  
23 child) in serious jeopardy,

24 “(II) serious impairment to bod-  
25 ily functions, or



1                   “(III) serious dysfunction of any  
2                   bodily organ or part,

3                   or

4                   “(ii) that immediate provision of the  
5                   care is necessary because the participant  
6                   or beneficiary has made or is at serious  
7                   risk of making an attempt to harm himself  
8                   or herself or another individual.

9                   “(J) INITIAL DECISION PERIOD.—The  
10                  term ‘initial decision period’ means a period of  
11                  30 days, or such longer period as may be pre-  
12                  scribed in regulations of the Secretary.

13                  “(K) INTERNAL REVIEW PERIOD.—The  
14                  term ‘internal review period’ means a period of  
15                  30 days, or such longer period as may be pre-  
16                  scribed in regulations of the Secretary.

17                  “(L) URGENT DECISION PERIOD.—The  
18                  term ‘urgent decision period’ means a period of  
19                  10 days, or such longer period as may be pre-  
20                  scribed in regulations of the Secretary.

21                  “(M) EMERGENCY DECISION PERIOD.—  
22                  The term ‘emergency decision period’ means a  
23                  period of 72 hours, or such longer period as  
24                  may be prescribed in regulations of the Sec-  
25                  retary.

1           “(N) SPECIALTY DECISION PERIOD.—The  
2           term ‘specialty decision period’ means a period  
3           of 72 hours, or such longer period as may be  
4           prescribed in regulations of the Secretary.

5           “(O) RECONSIDERATION PERIOD.—The  
6           term ‘reconsideration period’ means a period of  
7           25 days, or such longer period as may be pre-  
8           scribed in regulations of the Secretary, except  
9           that—

10                  “(i) in the case of a decision involving  
11                  urgent medical care, such term means the  
12                  urgent decision period, and

13                  “(ii) in the case of a decision involving  
14                  emergency medical care, such term means  
15                  the emergency decision period.

16           “(P) FILING COMPLETION DATE.—The  
17           term ‘filing completion date’ means, in connec-  
18           tion with a group health plan, the date as of  
19           which the plan is in receipt of all information  
20           reasonably required (in writing or in such other  
21           reasonable form as may be specified by the  
22           plan) to make an initial coverage decision.

23           “(Q) REVIEW FILING DATE.—The term  
24           ‘review filing date’ means, in connection with a  
25           group health plan, the date as of which the ap-

1           appropriate named fiduciary (or the independent  
2           medical expert or experts in the case of a review  
3           under paragraph (4)) is in receipt of all infor-  
4           mation reasonably required (in writing or in  
5           such other reasonable form as may be specified  
6           by the plan) to make a decision to affirm, mod-  
7           ify, or reverse a coverage decision.

8           “(R) MEDICAL CARE.—The term ‘medical  
9           care’ has the meaning provided such term by  
10          section 733(a)(2).

11          “(S) HEALTH INSURANCE COVERAGE.—  
12          The term ‘health insurance coverage’ has the  
13          meaning provided such term by section  
14          733(b)(1).

15          “(T) HEALTH INSURANCE ISSUER.—The  
16          term ‘health insurance issuer’ has the meaning  
17          provided such term by section 733(b)(2).

18          “(U) WRITTEN OR IN WRITING.—

19                 “(i) IN GENERAL.—A request or deci-  
20                 sion shall be deemed to be ‘written’ or ‘in  
21                 writing’ if such request or decision is pre-  
22                 sented in a generally recognized printable  
23                 or electronic format. The Secretary may by  
24                 regulation provide for presentation of in-  
25                 formation otherwise required to be in writ-

1           ten form in such other forms as may be  
2           appropriate under the circumstances.

3           “(ii) MEDICAL APPROPRIATENESS OR  
4           EXPERIMENTAL TREATMENT DETERMINA-  
5           TIONS.—For purposes of this subpara-  
6           graph, in the case of a request for advance  
7           determination of coverage, a request for  
8           expedited advance determination of cov-  
9           erage, a request for required determination  
10          of medical necessity, or a request for expe-  
11          dited required determination of medical ne-  
12          cessity, if the decision on such request is  
13          conveyed to the provider of medical care or  
14          to the participant or beneficiary by means  
15          of telephonic or other electronic commu-  
16          nications, such decision shall be treated as  
17          a written decision.”.

18       (b) CIVIL PENALTIES.—

19           (1) IN GENERAL.—Section 502(c) of such Act  
20       (29 U.S.C. 1132(c)) is amended by redesignating  
21       paragraphs (6) and (7) as paragraphs (7) and (8),  
22       respectively, and by inserting after paragraph (5)  
23       the following new paragraph:

24       “(6)(A)(i) In any case in which—

1           “(I) a benefit under a group health plan (as de-  
2       fined in section 503(b)(8)) is not timely provided to  
3       a participant or beneficiary pursuant to a final deci-  
4       sion of the plan which was not in accordance with  
5       the terms of the plan or this title, and

6           “(II) such final decision of the plan is contrary  
7       to a recommendation described in section  
8       503(b)(4)(C)(iii),

9       any person acting in the capacity of a fiduciary of such  
10      plan so as to cause such failure may, in the court’s discre-  
11      tion, be liable to the aggrieved participant or beneficiary  
12      for a civil penalty.

13       “(ii) Such civil penalty shall be in the amount of up  
14      to \$250 a day from the date on which the recommendation  
15      was made to the plan until the date the failure to provide  
16      benefits is corrected, up to a total amount not to exceed  
17      \$100,000.

18       “(B) In any action commenced under subsection (a)  
19      by a participant or beneficiary with respect to a group  
20      health plan (as defined in section 503(b)(8)) in which the  
21      plaintiff alleges that a person, in the capacity of a fidu-  
22      ciary and in violation of the terms of the plan or this title,  
23      has taken an action resulting in an adverse coverage deci-  
24      sion in violation of the terms of the plan, or has failed  
25      to take an action for which such person is responsible

1 under the plan and which is necessary under the plan for  
2 a favorable coverage decision, upon finding in favor of the  
3 plaintiff, if such action was commenced after a final deci-  
4 sion of the plan upon review which included a review under  
5 section 503(b)(4) or such action was commenced under  
6 subsection (b)(4) of this section, the court shall cause to  
7 be served on the defendant an order requiring the defend-  
8 ant—

9 “(i) to cease and desist from the alleged action  
10 or failure to act, and

11 “(ii) to pay to the plaintiff a reasonable attor-  
12 ney’s fee and other reasonable costs relating to the  
13 prosecution of the action on the charges on which  
14 the plaintiff prevails.

15 The remedies provided under this subparagraph shall be  
16 in addition to remedies otherwise provided under this sec-  
17 tion.

18 “(C)(i) The Secretary may assess a civil penalty  
19 against a person acting in the capacity of a fiduciary of  
20 one or more group health plans (as defined in section  
21 503(b)(8)) for—

22 “(I) any pattern or practice of repeated adverse  
23 coverage decisions in violation of the terms of the  
24 plan or plans or this title, or

1           “(II) any pattern or practice of repeated viola-  
2           tions of the requirements of section 503 with respect  
3           to such plan or plans.

4   Such penalty shall be payable only upon proof by clear  
5   and convincing evidence of such pattern or practice.

6           “(ii) Such penalty shall be in an amount not to exceed  
7   the lesser of—

8           “(I) 5 percent of the aggregate value of benefits  
9           shown by the Secretary to have not been provided,  
10          or unlawfully delayed in violation of section 503,  
11          under such pattern or practice, or

12          “(II) \$100,000.

13          “(iii) Any person acting in the capacity of a fiduciary  
14   of a group health plan or plans who has engaged in any  
15   such pattern or practice with respect to such plans, upon  
16   the petition of the Secretary, may be removed by the court  
17   from that position, and from any other involvement, with  
18   respect to such plan or plans, and may be precluded from  
19   returning to any such position or involvement for a period  
20   determined by the court.”.

21           (2)    CONFORMING    AMENDMENT.—Section  
22   502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is  
23   amended by striking “(6)” and inserting “(7)”.

24           (c)   EXPEDITED COURT REVIEW.—Section 502 of  
25   such Act (29 U.S.C. 1132) is amended—

1           (1) in subsection (a)(8), by striking “or” at the  
2       end;

3           (2) in subsection (a)(9), by striking the period  
4       and inserting “; or”;

5           (3) by adding at the end of subsection (a) the  
6       following new paragraph:

7       “(10) by a participant or beneficiary for appropriate  
8       relief under subsection (b)(4).”.

9           (4) by adding at the end of subsection (b) the  
10      following new paragraph:

11      “(4) In any case in which exhaustion of administra-  
12      tive remedies in accordance with paragraph (2)(A)(ii) or  
13      (2)(B)(ii) of section 503(b) otherwise necessary for an ac-  
14      tion for relief under paragraph (1)(B) or (3) of subsection  
15      (a) has not been obtained and it is demonstrated to the  
16      court by means of certification by an appropriate physi-  
17      cian that such exhaustion is not reasonably attainable  
18      under the facts and circumstances without undue risk of  
19      irreparable harm to the health of the participant or bene-  
20      ficiary, a civil action may be brought by a participant or  
21      beneficiary to obtain appropriate equitable relief. Any de-  
22      terminations made under paragraph (2)(A)(ii) or  
23      (2)(B)(ii) of section 503(b) made while an action under  
24      this paragraph is pending shall be given due consideration  
25      by the court in any such action.”.



1 (d) STANDARD OF REVIEW UNAFFECTED.—The  
 2 standard of review under section 502 of the Employee Re-  
 3 tirement Income Security Act of 1974 (as amended by this  
 4 section) shall continue on and after the date of the enact-  
 5 ment of this Act to be the standard of review which was  
 6 applicable under such section as of immediately before  
 7 such date.

8 (e) CONCURRENT JURISDICTION.—Section 502(e)(1)  
 9 of such Act (29 U.S.C. 1132(e)(1)) is amended—

10 (1) in the first sentence, by striking “under  
 11 subsection (a)(1)(B) of this section” and inserting  
 12 “under subsection (a)(1)(A) for relief under sub-  
 13 section (c)(6), under subsection (a)(1)(B), and  
 14 under subsection (b)(4)”; and

15 (2) in the last sentence, by striking “of actions  
 16 under paragraphs (1)(B) and (7) of subsection (a)  
 17 of this section” and inserting “of actions under  
 18 paragraph (1)(A) of subsection (a) for relief under  
 19 subsection (c)(6) and of actions under paragraphs  
 20 (1)(B) and (7) of subsection (a) and paragraph (4)  
 21 of subsection (b)”.

22 **SEC. 1202. EFFECTIVE DATE.**

23 (a) IN GENERAL.—The amendments made by this  
 24 subtitle shall apply with respect to grievances arising in  
 25 plan years beginning on or after January 1 of the second

1 calendar year following the date of the enactment of this  
2 Act. The Secretary shall first issue all regulations nec-  
3 essary to carry out the amendments made by this subtitle  
4 before such date.

5 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
6 enforcement action shall be taken, pursuant to the amend-  
7 ments made by this subtitle, against a group health plan  
8 or health insurance issuer with respect to a violation of  
9 a requirement imposed by such amendments before the  
10 date of issuance of final regulations issued in connection  
11 with such requirement, if the plan or issuer has sought  
12 to comply in good faith with such requirement.

13 (c) COLLECTIVE BARGAINING AGREEMENTS.—Any  
14 plan amendment made pursuant to a collective bargaining  
15 agreement relating to the plan which amends the plan  
16 solely to conform to any requirement added by this subtitle  
17 shall not be treated as a termination of such collective bar-  
18 gaining agreement.

19 **Subtitle D—Affordable Health Cov-**  
20 **erage for Employees of Small**  
21 **Businesses**

22 **SEC. 1301. SHORT TITLE OF SUBTITLE.**

23 This subtitle may be cited as the “Small Business  
24 Affordable Health Coverage Act of 1998”.

1 **SEC. 1302. RULES GOVERNING ASSOCIATION HEALTH**  
2 **PLANS.**

3 (a) IN GENERAL.—Subtitle B of title I of the Em-  
4 ployee Retirement Income Security Act of 1974 is amend-  
5 ed by adding after part 7 the following new part:

6 “PART 8—RULES GOVERNING ASSOCIATION HEALTH  
7 PLANS

8 **“SEC. 801. ASSOCIATION HEALTH PLANS.**

9 “(a) IN GENERAL.—For purposes of this part, the  
10 term ‘association health plan’ means a group health  
11 plan—

12 “(1) whose sponsor is (or is deemed under this  
13 part to be) described in subsection (b), and

14 “(2) under which at least one option of health  
15 insurance coverage offered by a health insurance  
16 issuer (which may include, among other options,  
17 managed care options, point of service options, and  
18 preferred provider options) is provided to partici-  
19 pants and beneficiaries, unless, for any plan year,  
20 such coverage remains unavailable to the plan de-  
21 spite good faith efforts exercised by the plan to se-  
22 cure such coverage.

23 “(b) SPONSORSHIP.—The sponsor of a group health  
24 plan is described in this subsection if such sponsor—

25 “(1) is organized and maintained in good faith,  
26 with a constitution and bylaws specifically stating its

1 purpose and providing for periodic meetings on at  
2 least an annual basis, as a trade association, an in-  
3 dustry association (including a rural electric cooper-  
4 ative association or a rural telephone cooperative as-  
5 sociation), a professional association, or a chamber  
6 of commerce (or similar business association, includ-  
7 ing a corporation or similar organization that oper-  
8 ates on a cooperative basis (within the meaning of  
9 section 1381 of the Internal Revenue Code of  
10 1986)), for substantial purposes other than that of  
11 obtaining or providing medical care,

12 “(2) is established as a permanent entity which  
13 receives the active support of its members and col-  
14 lects from its members on a periodic basis dues or  
15 payments necessary to maintain eligibility for mem-  
16 bership in the sponsor, and

17 “(3) does not condition membership, such dues  
18 or payments, or coverage under the plan on the  
19 basis of health status-related factors with respect to  
20 the employees of its members (or affiliated mem-  
21 bers), or the dependents of such employees, and does  
22 not condition such dues or payments on the basis of  
23 group health plan participation.

1 Any sponsor consisting of an association of entities which  
 2 meet the requirements of paragraphs (1) and (2) shall be  
 3 deemed to be a sponsor described in this subsection.

4 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**  
 5 **PLANS.**

6 “(a) IN GENERAL.—The applicable authority shall  
 7 prescribe by regulation a procedure under which, subject  
 8 to subsection (b), the applicable authority shall certify as-  
 9 sociation health plans which apply for certification as  
 10 meeting the requirements of this part.

11 “(b) STANDARDS.—Under the procedure prescribed  
 12 pursuant to subsection (a), the applicable authority shall  
 13 certify an association health plan as meeting the require-  
 14 ments of this part only if the applicable authority is satis-  
 15 fied that—

16 “(1) such certification—

17 “(A) is administratively feasible,

18 “(B) is not adverse to the interests of the  
 19 individuals covered under the plan, and

20 “(C) is protective of the rights and benefits  
 21 of the individuals covered under the plan, and

22 “(2) the applicable requirements of this part  
 23 are met (or, upon the date on which the plan is to  
 24 commence operations, will be met) with respect to  
 25 the plan.

1       “(c) REQUIREMENTS APPLICABLE TO CERTIFIED  
2 PLANS.—An association health plan with respect to which  
3 certification under this part is in effect shall meet the ap-  
4 plicable requirements of this part, effective on the date  
5 of certification (or, if later, on the date on which the plan  
6 is to commence operations).

7       “(d) REQUIREMENTS FOR CONTINUED CERTIFI-  
8 CATION.—The applicable authority may provide by regula-  
9 tion for continued certification of association health plans  
10 under this part, including requirements relating to com-  
11 mencement of new benefit options by plans which do not  
12 consist of health insurance coverage.

13       “(e) CLASS CERTIFICATION FOR FULLY INSURED  
14 PLANS.—The applicable authority shall establish a class  
15 certification procedure for association health plans under  
16 which all benefits consist of health insurance coverage.  
17 Under such procedure, the applicable authority shall pro-  
18 vide for the granting of certification under this part to  
19 the plans in each class of such association health plans  
20 upon appropriate filing under such procedure in connec-  
21 tion with plans in such class and payment of the pre-  
22 scribed fee under section 807(a).

1   **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**  
2                   **BOARDS OF TRUSTEES.**

3           “(a) SPONSOR.—The requirements of this subsection  
4 are met with respect to an association health plan if—

5                   “(1) the sponsor (together with its immediate  
6 predecessor, if any) has met (or is deemed under  
7 this part to have met) for a continuous period of not  
8 less than 3 years ending with the date of the appli-  
9 cation for certification under this part, the require-  
10 ments of paragraphs (1) and (2) of section 801(b),  
11 and

12                   “(2) the sponsor meets (or is deemed under this  
13 part to meet) the requirements of section 801(b)(3).

14           “(b) BOARD OF TRUSTEES.—The requirements of  
15 this subsection are met with respect to an association  
16 health plan if the following requirements are met:

17                   “(1) FISCAL CONTROL.—The plan is operated,  
18 pursuant to a trust agreement, by a board of trust-  
19 ees which has complete fiscal control over the plan  
20 and which is responsible for all operations of the  
21 plan.

22                   “(2) RULES OF OPERATION AND FINANCIAL  
23 CONTROLS.—The board of trustees has in effect  
24 rules of operation and financial controls, based on a  
25 3-year plan of operation, adequate to carry out the

1 terms of the plan and to meet all requirements of  
2 this title applicable to the plan.

3 “(3) RULES GOVERNING RELATIONSHIP TO  
4 PARTICIPATING EMPLOYERS AND TO CONTRAC-  
5 TORS.—

6 “(A) IN GENERAL.—Except as provided in  
7 subparagraph (B), the members of the board of  
8 trustees are individuals selected from individ-  
9 uals who are the owners, officers, directors, or  
10 employees of the participating employers or who  
11 are partners in the participating employers and  
12 actively participate in the business.

13 “(B) LIMITATION.—

14 “(i) GENERAL RULE.—Except as pro-  
15 vided in clauses (ii) and (iii), no such  
16 member is an owner, officer, director, or  
17 employee of, or partner in, a contract ad-  
18 ministrator or other service provider to the  
19 plan.

20 “(ii) LIMITED EXCEPTION FOR PRO-  
21 VIDERS OF SERVICES SOLELY ON BEHALF  
22 OF THE SPONSOR.—Officers or employees  
23 of a sponsor which is a service provider  
24 (other than a contract administrator) to  
25 the plan may be members of the board if



1           they constitute not more than 25 percent  
2           of the membership of the board and they  
3           do not provide services to the plan other  
4           than on behalf of the sponsor.

5           “(iii) TREATMENT OF PROVIDERS OF  
6           MEDICAL CARE.—In the case of a sponsor  
7           which is an association whose membership  
8           consists primarily of providers of medical  
9           care, clause (i) shall not apply in the case  
10          of any service provider described in sub-  
11          paragraph (A) who is a provider of medical  
12          care under the plan.

13          “(C) SOLE AUTHORITY.—The board has  
14          sole authority to approve applications for par-  
15          ticipation in the plan and to contract with a  
16          service provider to administer the day-to-day af-  
17          fairs of the plan.

18          “(c) TREATMENT OF FRANCHISE NETWORKS.—In  
19          the case of a group health plan which is established and  
20          maintained by a franchiser for a franchise network con-  
21          sisting of its franchisees—

22                 “(1) the requirements of subsection (a) and sec-  
23          tion 801(a)(1) shall be deemed met if such require-  
24          ments would otherwise be met if the franchiser were  
25          deemed to be the sponsor referred to in section

1       801(b), such network were deemed to be an associa-  
 2       tion described in section 801(b), and each franchisee  
 3       were deemed to be a member (of the association and  
 4       the sponsor) referred to in section 801(b), and

5               “(2) the requirements of section 804(a)(1) shall  
 6       be deemed met.

7       “(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

8               “(1) IN GENERAL.—In the case of a group  
 9       health plan described in paragraph (2)—

10               “(A) the requirements of subsection (a)  
 11       and section 801(a)(1) shall be deemed met,

12               “(B) the joint board of trustees shall be  
 13       deemed a board of trustees with respect to  
 14       which the requirements of subsection (b) are  
 15       met, and

16               “(C) the requirements of section 804 shall  
 17       be deemed met.

18       “(2) REQUIREMENTS.—A group health plan is  
 19       described in this paragraph if—

20               “(A) the plan is a multiemployer plan, or

21               “(B) the plan is in existence on April 1,  
 22       1997, and would be described in section  
 23       3(40)(A)(i) but solely for the failure to meet  
 24       the requirements of section 3(40)(C)(ii).

1 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**  
2 **MENTS.**

3 “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The  
4 requirements of this subsection are met with respect to  
5 an association health plan if, under the terms of the  
6 plan—

7 “(1) all participating employers must be mem-  
8 bers or affiliated members of the sponsor, except  
9 that, in the case of a sponsor which is a professional  
10 association or other individual-based association, if  
11 at least one of the officers, directors, or employees  
12 of an employer, or at least one of the individuals  
13 who are partners in an employer and who actively  
14 participates in the business, is a member or affili-  
15 ated member of the sponsor, participating employers  
16 may also include such employer, and

17 “(2) all individuals commencing coverage under  
18 the plan after certification under this part must  
19 be—

20 “(A) active or retired owners (including  
21 self-employed individuals), officers, directors, or  
22 employees of, or partners in, participating em-  
23 ployers, or

24 “(B) the beneficiaries of individuals de-  
25 scribed in subparagraph (A).

1       “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-  
2   PLOYEES.—

3               “(1) IN GENERAL.—Subject to paragraph (2),  
4       the requirements of this subsection are met with re-  
5       spect to an association health plan if, under the  
6       terms of the plan, no affiliated member of the spon-  
7       sor may be offered coverage under the plan as a par-  
8       ticipating employer, unless—

9               “(A) the affiliated member was an affili-  
10       ated member on the date of certification under  
11       this part, or

12              “(B) during the 12-month period preced-  
13       ing the date of the offering of such coverage,  
14       the affiliated member has not maintained or  
15       contributed to a group health plan with respect  
16       to any of its employees who would otherwise be  
17       eligible to participate in such association health  
18       plan.

19              “(2) LIMITATION.—The requirements of this  
20       subsection shall apply only in the case of plans  
21       which were in existence on the date of the enactment  
22       of the Small Business Affordable Health Coverage  
23       Act of 1998.

24              “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-  
25       quirements of this subsection are met with respect to an

1 association health plan if, under the terms of the plan,  
2 no participating employer may provide health insurance  
3 coverage in the individual market for any employee not  
4 covered under the plan which is similar to the coverage  
5 contemporaneously provided to employees of the employer  
6 under the plan, if such exclusion of the employee from cov-  
7 erage under the plan is based on a health status-related  
8 factor with respect to the employee and such employee  
9 would, but for such exclusion on such basis, be eligible  
10 for coverage under the plan.

11 “(d) PROHIBITION OF DISCRIMINATION AGAINST  
12 EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICI-  
13 PATE.—The requirements of this subsection are met with  
14 respect to an association health plan if—

15 “(1) under the terms of the plan, no employer  
16 meeting the preceding requirements of this section is  
17 excluded as a participating employer, unless partici-  
18 pation or contribution requirements of the type re-  
19 ferred to in section 2711 of the Public Health Serv-  
20 ice Act are not met with respect to the excluded em-  
21 ployer,

22 “(2) the applicable requirements of sections  
23 701, 702, and 703 are met with respect to the plan,  
24 and

1           “(3) applicable benefit options under the plan  
2           are actively marketed to all eligible participating em-  
3           ployers.

4   **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**  
5                   **DOCUMENTS, CONTRIBUTION RATES, AND**  
6                   **BENEFIT OPTIONS.**

7           “(a) IN GENERAL.—The requirements of this section  
8           are met with respect to an association health plan if the  
9           following requirements are met:

10           “(1) CONTENTS OF GOVERNING INSTRU-  
11           MENTS.—The instruments governing the plan in-  
12           clude a written instrument, meeting the require-  
13           ments of an instrument required under section  
14           402(a)(1), which—

15           “(A) provides that the board of trustees  
16           serves as the named fiduciary required for plans  
17           under section 402(a)(1) and serves in the ca-  
18           pacity of a plan administrator (referred to in  
19           section 3(16)(A)),

20           “(B) provides that the sponsor of the plan  
21           is to serve as plan sponsor (referred to in sec-  
22           tion 3(16)(B)), and

23           “(C) incorporates the requirements of sec-  
24           tion 806.

1           “(2) CONTRIBUTION RATES MUST BE NON-  
2 DISCRIMINATORY.—

3           “(A) The contribution rates for any par-  
4 ticipating small employer do not vary on the  
5 basis of the claims experience of such employer  
6 and do not vary on the basis of the type of  
7 business or industry in which such employer is  
8 engaged.

9           “(B) Nothing in this title or any other pro-  
10 vision of law shall be construed to preclude an  
11 association health plan, or a health insurance  
12 issuer offering health insurance coverage in  
13 connection with an association health plan,  
14 from

15           “(i) setting contribution rates based  
16 on the claims experience of the plan, or

17           “(ii) varying contribution rates for  
18 small employers in a State to the extent  
19 that such rates could vary using the same  
20 methodology employed in such State for  
21 regulating premium rates in the small  
22 group market,  
23 subject to the requirements of section 702(b)  
24 relating to contribution rates.

1           “(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If  
2           any benefit option under the plan does not consist  
3           of health insurance coverage, the plan has as of the  
4           beginning of the plan year not fewer than 1,000 participants and beneficiaries.  
6

7           “(4) MARKETING REQUIREMENTS.—

8           “(A) IN GENERAL.—If a benefit option  
9           which consists of health insurance coverage is  
10          offered under the plan, State-licensed insurance  
11          agents shall be used to distribute to small employers coverage which does not consist of  
12          health insurance coverage in a manner comparable to the manner in which such agents are  
13          used to distribute health insurance coverage.  
15

16          “(B) STATE-LICENSED INSURANCE  
17          AGENTS.—For purposes of subparagraph (A),  
18          the term ‘State-licensed insurance agents’  
19          means one or more agents who are licensed in  
20          a State and are subject to the laws of such  
21          State relating to licensure, qualification, testing, examination, and continuing education of  
22          persons authorized to offer, sell, or solicit  
23          health insurance coverage in such State.  
24



1           “(5) REGULATORY REQUIREMENTS.—Such  
2           other requirements as the applicable authority may  
3           prescribe by regulation as necessary to carry out the  
4           purposes of this part.

5           “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO  
6 DESIGN BENEFIT OPTIONS.—Nothing in this part or any  
7 provision of State law (as defined in section 514(c)(1))  
8 shall be construed to preclude an association health plan,  
9 or a health insurance issuer offering health insurance cov-  
10 erage in connection with an association health plan, from  
11 exercising its sole discretion in selecting the specific items  
12 and services consisting of medical care to be included as  
13 benefits under such plan or coverage, except (subject to  
14 section 514) in the case of any law to the extent that it  
15 (1) prohibits an exclusion of a specific disease from such  
16 coverage, or (2) is not preempted under section 731(a)(1)  
17 with respect to matters governed by section 711 or 712.

18 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**  
19 **FOR SOLVENCY FOR PLANS PROVIDING**  
20 **HEALTH BENEFITS IN ADDITION TO HEALTH**  
21 **INSURANCE COVERAGE.**

22           “(a) IN GENERAL.—The requirements of this section  
23 are met with respect to an association health plan if—

24           “(1) the benefits under the plan consist solely  
25           of health insurance coverage, or

1           “(2) if the plan provides any additional benefit  
2 options which do not consist of health insurance cov-  
3 erage, the plan—

4           “(A) establishes and maintains reserves  
5 with respect to such additional benefit options,  
6 in amounts recommended by the qualified actu-  
7 ary, consisting of—

8           “(i) a reserve sufficient for unearned  
9 contributions,

10           “(ii) a reserve sufficient for benefit li-  
11 abilities which have been incurred, which  
12 have not been satisfied, and for which risk  
13 of loss has not yet been transferred, and  
14 for expected administrative costs with re-  
15 spect to such benefit liabilities,

16           “(iii) a reserve sufficient for any other  
17 obligations of the plan, and

18           “(iv) a reserve sufficient for a margin  
19 of error and other fluctuations, taking into  
20 account the specific circumstances of the  
21 plan,

22           and

23           “(B) establishes and maintains aggregate  
24 and specific excess/stop loss insurance and sol-  
25 vency indemnification, with respect to such ad-

ditional benefit options for which risk of loss  
has not yet been transferred, as follows:

“(i) The plan shall secure aggregate  
excess/stop loss insurance for the plan with  
an attachment point which is not greater  
than 125 percent of expected gross annual  
claims. The applicable authority may by  
regulation provide for upward adjustments  
in the amount of such percentage in speci-  
fied circumstances in which the plan spe-  
cifically provides for and maintains re-  
serves in excess of the amounts required  
under subparagraph (A).

“(ii) The plan shall secure specific ex-  
cess/stop loss insurance for the plan with  
an attachment point which is at least equal  
to an amount recommended by the plan’s  
qualified actuary (but not more than  
\$200,000). The applicable authority may  
by regulation provide for adjustments in  
the amount of such insurance in specified  
circumstances in which the plan specifically  
provides for and maintains reserves in ex-  
cess of the amounts required under sub-  
paragraph (A).

1                   “(iii) The plan shall secure indem-  
2                   nification insurance for any claims which  
3                   the plan is unable to satisfy by reason of  
4                   a plan termination.

5 Any regulations prescribed by the applicable authority  
6 pursuant to clause (i) or (ii) of subparagraph (B) may  
7 allow for such adjustments in the required levels of excess/  
8 stop loss insurance as the qualified actuary may rec-  
9 ommend, taking into account the specific circumstances  
10 of the plan.

11       “(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS  
12 RESERVES.—The requirements of this subsection are met  
13 if the plan establishes and maintains surplus in an amount  
14 at least equal to \$2,000,000, reduced in accordance with  
15 a scale, prescribed in regulations of the applicable author-  
16 ity to an amount not less than \$500,000, based on the  
17 level of aggregate and specific excess/stop loss insurance  
18 provided with respect to such plan.

19       “(c) ADDITIONAL REQUIREMENTS.—In the case of  
20 any association health plan described in subsection (a)(2),  
21 the applicable authority may provide such additional re-  
22 quirements relating to reserves and excess/stop loss insur-  
23 ance as the applicable authority considers appropriate.  
24 Such requirements may be provided, by regulation or oth-

1 erwise, with respect to any such plan or any class of such  
2 plans.

3 “(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-  
4 ANCE.—The applicable authority may provide for adjust-  
5 ments to the levels of reserves otherwise required under  
6 subsections (a) and (b) with respect to any plan or class  
7 of plans to take into account excess/stop loss insurance  
8 provided with respect to such plan or plans.

9 “(e) ALTERNATIVE MEANS OF COMPLIANCE.—The  
10 applicable authority may permit an association health plan  
11 described in subsection (a)(2) to substitute, for all or part  
12 of the requirements of this section (except subsection  
13 (a)(2)(B)(iii)), such security, guarantee, hold-harmless ar-  
14 rangement, or other financial arrangement as the applica-  
15 ble authority determines to be adequate to enable the plan  
16 to fully meet all its financial obligations on a timely basis  
17 and is otherwise no less protective of the interests of par-  
18 ticipants and beneficiaries than the requirements for  
19 which it is substituted. The applicable authority may take  
20 into account, for purposes of this subsection, evidence pro-  
21 vided by the plan or sponsor which demonstrates an as-  
22 sumption of liability with respect to the plan. Such evi-  
23 dence may be in the form of a contract of indemnification,  
24 lien, bonding, insurance, letter of credit, recourse under  
25 applicable terms of the plan in the form of assessments

1 of participating employers, security, or other financial ar-  
2 rangement.

3 “(f) MEASURES TO ENSURE CONTINUED PAYMENT  
4 OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

5 “(1) PAYMENTS BY CERTAIN PLANS TO ASSO-  
6 CIATION HEALTH PLAN FUND.—

7 “(A) IN GENERAL.—In the case of an as-  
8 sociation health plan described in subsection  
9 (a)(2), the requirements of this subsection are  
10 met if the plan makes payments into the Asso-  
11 ciation Health Plan Fund under this subpara-  
12 graph when they are due. Such payments shall  
13 consist of annual payments in the amount of  
14 \$5,000, and, in addition to such annual pay-  
15 ments, such supplemental payments as the Sec-  
16 retary may determine to be necessary under  
17 paragraph (2). Payments under this paragraph  
18 are payable to the Fund at the time determined  
19 by the Secretary. Initial payments are due in  
20 advance of certification under this part. Pay-  
21 ments shall continue to accrue until a plan’s as-  
22 sets are distributed pursuant to a termination  
23 procedure.

24 “(B) PENALTIES FOR FAILURE TO MAKE  
25 PAYMENTS.—If any payment is not made by a

1 plan when it is due, a late payment charge of  
2 not more than 100 percent of the payment  
3 which was not timely paid shall be payable by  
4 the plan to the Fund.

5 “(C) CONTINUED DUTY OF THE SEC-  
6 RETARY.—The Secretary shall not cease to  
7 carry out the provisions of paragraph (2) on ac-  
8 count of the failure of a plan to pay any pay-  
9 ment when due.

10 “(2) PAYMENTS BY SECRETARY TO CONTINUE  
11 EXCESS STOP/LOSS INSURANCE COVERAGE AND IN-  
12 DEMNIFICATION INSURANCE COVERAGE FOR CER-  
13 TAIN PLANS.—In any case in which the applicable  
14 authority determines that there is, or that there is  
15 reason to believe that there will be, (A) a failure to  
16 take necessary corrective actions under section  
17 809(a) with respect to an association health plan de-  
18 scribed in subsection (a)(2), or (B) a termination of  
19 such a plan under section 809(b) or 810(b)(8) (and,  
20 if the applicable authority is not the Secretary, cer-  
21 tifies such determination to the Secretary), the Sec-  
22 retary shall determine the amounts necessary to  
23 make payments to an insurer (designated by the  
24 Secretary) to maintain in force excess/stop loss in-  
25 surance coverage or indemnification insurance cov-

1        erage for such plan, if the Secretary determines that  
2        there is a reasonable expectation that, without such  
3        payments, claims would not be satisfied by reason of  
4        termination of such coverage. The Secretary shall, to  
5        the extent provided in advance in appropriation  
6        Acts, pay such amounts so determined to the insurer  
7        designated by the Secretary.

8            “(3) ASSOCIATION HEALTH PLAN FUND.—

9            “(A) IN GENERAL.—There is established  
10        on the books of the Treasury a fund to be  
11        known as the ‘Association Health Plan Fund’.  
12        The Fund shall be available for making pay-  
13        ments pursuant to paragraph (2). The Fund  
14        shall be credited with payments received pursu-  
15        ant to paragraph (1)(A), penalties received pur-  
16        suant to paragraph (1)(B), and earnings on in-  
17        vestments of amounts of the Fund under sub-  
18        paragraph (B).

19        “(B) INVESTMENT.—Whenever the Sec-  
20        retary determines that the moneys of the fund  
21        are in excess of current needs, the Secretary  
22        may request the investment of such amounts as  
23        the Secretary determines advisable by the Sec-  
24        retary of the Treasury in obligations issued or  
25        guaranteed by the United States.



1       “(g) EXCESS/STOP LOSS INSURANCE.—For purposes  
2 of this section—

3           “(1) AGGREGATE EXCESS/STOP LOSS INSUR-  
4 ANCE.—The term ‘aggregate excess/stop loss insur-  
5 ance’ means, in connection with an association  
6 health plan, a contract—

7           “(A) under which an insurer (meeting such  
8 minimum standards as may be prescribed in regula-  
9 tions of the applicable authority) provides for pay-  
10 ment to the plan with respect to aggregate claims  
11 under the plan in excess of an amount or amounts  
12 specified in such contract,

13           “(B) which is guaranteed renewable, and

14           “(C) which allows for payment of premiums by  
15 any third party on behalf of the insured plan.

16           “(2) SPECIFIC EXCESS/STOP LOSS INSUR-  
17 ANCE.—The term ‘specific excess/stop loss insur-  
18 ance’ means , in connection with an association  
19 health plan, a contract—

20           “(A) under which an insurer (meeting such  
21 minimum standards as may be prescribed in  
22 regulations of the applicable authority) provides  
23 for payment to the plan with respect to claims  
24 under the plan in connection with a covered in-  
25 dividual in excess of an amount or amounts

1 specified in such contract in connection with  
2 such covered individual,

3 “(B) which is guaranteed renewable, and

4 “(C) which allows for payment of pre-  
5 miums by any third party on behalf of the in-  
6 sured plan.

7 “(h) INDEMNIFICATION INSURANCE.—For purposes  
8 of this section, the term ‘indemnification insurance’  
9 means, in connection with an association health plan, a  
10 contract—

11 “(1) under which an insurer (meeting such min-  
12 imum standards as may be prescribed in regulations  
13 of the applicable authority) provides for payment to  
14 the plan with respect to claims under the plan which  
15 the plan is unable to satisfy by reason of a termi-  
16 nation pursuant to section 809(b) (relating to man-  
17 datory termination),

18 “(2) which is guaranteed renewable and  
19 noncancellable for any reason (except as may be pro-  
20 vided in regulations of the applicable authority), and

21 “(3) which allows for payment of premiums by  
22 any third party on behalf of the insured plan.

23 “(i) RESERVES.—For purposes of this section, the  
24 term ‘reserves’ means, in connection with an association  
25 health plan, plan assets which meet the fiduciary stand-

1 ards under part 4 and such additional requirements re-  
2 garding liquidity as may be prescribed in regulations of  
3 the applicable authority.

4 “(j) REGULATIONS PRESCRIBED UNDER NEGO-  
5 TIATED RULEMAKING.—The regulations under this sec-  
6 tion shall be prescribed under negotiated rulemaking in  
7 accordance with subchapter III of chapter 5 of title 5,  
8 United States Code, except that, in establishing the nego-  
9 tiated rulemaking committee for purposes of such rule-  
10 making, the applicable authority shall include among per-  
11 sons invited to membership on the committee at least one  
12 of each of the following:

13 “(1) a representative of the National Associa-  
14 tion of Insurance Commissioners,

15 “(2) a representative of the American Academy  
16 of Actuaries,

17 “(3) a representative of the State governments,  
18 or their interests,

19 “(4) a representative of existing self-insured ar-  
20 rangements, or their interests,

21 “(5) a representative of associations of the type  
22 referred to in section 801(b)(1), or their interests,  
23 and

24 “(6) a representative of multiemployer plans  
25 that are group health plans, or their interests.

1   **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RELAT-**  
2                   **ED REQUIREMENTS.**

3           “(a) **FILING FEE.**—Under the procedure prescribed  
4 pursuant to section 802(a), an association health plan  
5 shall pay to the applicable authority at the time of filing  
6 an application for certification under this part a filing fee  
7 in the amount of \$5,000, which shall be available in the  
8 case of the Secretary, to the extent provided in appropria-  
9 tion Acts, for the sole purpose of administering the certifi-  
10 cation procedures applicable with respect to association  
11 health plans.

12          “(b) **INFORMATION TO BE INCLUDED IN APPLICA-**  
13 **TION FOR CERTIFICATION.**—An application for certifi-  
14 cation under this part meets the requirements of this sec-  
15 tion only if it includes, in a manner and form prescribed  
16 in regulations of the applicable authority, at least the fol-  
17 lowing information:

18               “(1) **IDENTIFYING INFORMATION.**—The names  
19               and addresses of—

20                       “(A) the sponsor, and

21                       “(B) the members of the board of trustees  
22               of the plan.

23               “(2) **STATES IN WHICH PLAN INTENDS TO DO**  
24 **BUSINESS.**—The States in which participants and  
25 beneficiaries under the plan are to be located and

1 the number of them expected to be located in each  
2 such State.

3 “(3) BONDING REQUIREMENTS.—Evidence pro-  
4 vided by the board of trustees that the bonding re-  
5 quirements of section 412 will be met as of the date  
6 of the application or (if later) commencement of op-  
7 erations.

8 “(4) PLAN DOCUMENTS.—A copy of the docu-  
9 ments governing the plan (including any bylaws and  
10 trust agreements), the summary plan description,  
11 and other material describing the benefits that will  
12 be provided to participants and beneficiaries under  
13 the plan.

14 “(5) AGREEMENTS WITH SERVICE PROVID-  
15 ERS.—A copy of any agreements between the plan  
16 and contract administrators and other service pro-  
17 viders.

18 “(6) FUNDING REPORT.—In the case of asso-  
19 ciation health plans providing benefits options in ad-  
20 dition to health insurance coverage, a report setting  
21 forth information with respect to such additional  
22 benefit options determined as of a date within the  
23 120-day period ending with the date of the applica-  
24 tion, including the following:

1           “(A) RESERVES.—A statement, certified  
2           by the board of trustees of the plan, and a  
3           statement of actuarial opinion, signed by a  
4           qualified actuary, that all applicable require-  
5           ments of section 806 are or will be met in ac-  
6           cordance with regulations which the applicable  
7           authority shall prescribe.

8           “(B) ADEQUACY OF CONTRIBUTION  
9           RATES.—A statement of actuarial opinion,  
10          signed by a qualified actuary, which sets forth  
11          a description of the extent to which contribution  
12          rates are adequate to provide for the payment  
13          of all obligations and the maintenance of re-  
14          quired reserves under the plan for the 12-  
15          month period beginning with such date within  
16          such 120-day period, taking into account the  
17          expected coverage and experience of the plan. If  
18          the contribution rates are not fully adequate,  
19          the statement of actuarial opinion shall indicate  
20          the extent to which the rates are inadequate  
21          and the changes needed to ensure adequacy.

22          “(C) CURRENT AND PROJECTED VALUE OF  
23          ASSETS AND LIABILITIES.—A statement of ac-  
24          tuarial opinion signed by a qualified actuary,  
25          which sets forth the current value of the assets

1 and liabilities accumulated under the plan and  
2 a projection of the assets, liabilities, income,  
3 and expenses of the plan for the 12-month pe-  
4 riod referred to in subparagraph (B). The in-  
5 come statement shall identify separately the  
6 plan's administrative expenses and claims.

7 “(D) COSTS OF COVERAGE TO BE  
8 CHARGED AND OTHER EXPENSES.—A state-  
9 ment of the costs of coverage to be charged, in-  
10 cluding an itemization of amounts for adminis-  
11 tration, reserves, and other expenses associated  
12 with the operation of the plan.

13 “(E) OTHER INFORMATION.—Any other  
14 information which may be prescribed in regula-  
15 tions of the applicable authority as necessary to  
16 carry out the purposes of this part.

17 “(c) FILING NOTICE OF CERTIFICATION WITH  
18 STATES.—A certification granted under this part to an  
19 association health plan shall not be effective unless written  
20 notice of such certification is filed with the applicable  
21 State authority of each State in which at least 25 percent  
22 of the participants and beneficiaries under the plan are  
23 located. For purposes of this subsection, an individual  
24 shall be considered to be located in the State in which a

1 known address of such individual is located or in which  
2 such individual is employed.

3 “(d) NOTICE OF MATERIAL CHANGES.—In the case  
4 of any association health plan certified under this part,  
5 descriptions of material changes in any information which  
6 was required to be submitted with the application for the  
7 certification under this part shall be filed in such form  
8 and manner as shall be prescribed in regulations of the  
9 applicable authority. The applicable authority may require  
10 by regulation prior notice of material changes with respect  
11 to specified matters which might serve as the basis for  
12 suspension or revocation of the certification.

13 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-  
14 SOCIATION HEALTH PLANS.—An association health plan  
15 certified under this part which provides benefit options in  
16 addition to health insurance coverage for such plan year  
17 shall meet the requirements of section 103 by filing an  
18 annual report under such section which shall include infor-  
19 mation described in subsection (b)(6) with respect to the  
20 plan year and, notwithstanding section 104(a)(1)(A), shall  
21 be filed with the applicable authority not later than 90  
22 days after the close of the plan year (or on such later date  
23 as may be prescribed by the applicable authority).

24 “(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The  
25 board of trustees of each association health plan which



1 provides benefits options in addition to health insurance  
2 coverage and which is applying for certification under this  
3 part or is certified under this part shall engage, on behalf  
4 of all participants and beneficiaries, a qualified actuary  
5 who shall be responsible for the preparation of the mate-  
6 rials comprising information necessary to be submitted by  
7 a qualified actuary under this part. The qualified actuary  
8 shall utilize such assumptions and techniques as are nec-  
9 essary to enable such actuary to form an opinion as to  
10 whether the contents of the matters reported under this  
11 part—

12           “(1) are in the aggregate reasonably related to  
13       the experience of the plan and to reasonable expecta-  
14       tions, and

15           “(2) represent such actuary’s best estimate of  
16       anticipated experience under the plan.

17 The opinion by the qualified actuary shall be made with  
18 respect to, and shall be made a part of, the annual report.

19 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
20 **MINATION.**

21       “Except as provided in section 809(b), an association  
22 health plan which is or has been certified under this part  
23 may terminate (upon or at any time after cessation of ac-  
24 cruals in benefit liabilities) only if the board of trustees—

1           “(1) not less than 60 days before the proposed  
2           termination date, provides to the participants and  
3           beneficiaries a written notice of intent to terminate  
4           stating that such termination is intended and the  
5           proposed termination date,

6           “(2) develops a plan for winding up the affairs  
7           of the plan in connection with such termination in  
8           a manner which will result in timely payment of all  
9           benefits for which the plan is obligated, and

10           “(3) submits such plan in writing to the appli-  
11           cable authority.

12   Actions required under this section shall be taken in such  
13   form and manner as may be prescribed in regulations of  
14   the applicable authority.

15   **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**  
16           **NATION.**

17           “(a) ACTIONS TO AVOID DEPLETION OF RE-  
18   SERVES.—An association health plan which is certified  
19   under this part and which provides benefits other than  
20   health insurance coverage shall continue to meet the re-  
21   quirements of section 806, irrespective of whether such  
22   certification continues in effect. The board of trustees of  
23   such plan shall determine quarterly whether the require-  
24   ments of section 806 are met. In any case in which the  
25   board determines that there is reason to believe that there

1 is or will be a failure to meet such requirements, or the  
2 applicable authority makes such a determination and so  
3 notifies the board, the board shall immediately notify the  
4 qualified actuary engaged by the plan, and such actuary  
5 shall, not later than the end of the next following month,  
6 make such recommendations to the board for corrective  
7 action as the actuary determines necessary to ensure com-  
8 pliance with section 806. Not later than 30 days after re-  
9 ceiving from the actuary recommendations for corrective  
10 actions, the board shall notify the applicable authority (in  
11 such form and manner as the applicable authority may  
12 prescribe by regulation) of such recommendations of the  
13 actuary for corrective action, together with a description  
14 of the actions (if any) that the board has taken or plans  
15 to take in response to such recommendations. The board  
16 shall thereafter report to the applicable authority, in such  
17 form and frequency as the applicable authority may speci-  
18 fy to the board, regarding corrective action taken by the  
19 board until the requirements of section 806 are met.

20 “(b) MANDATORY TERMINATION.—In any case in  
21 which—

22 “(1) the applicable authority has been notified  
23 under subsection (a) of a failure of an association  
24 health plan which is or has been certified under this  
25 part and is described in section 806(a)(2) to meet

1 the requirements of section 806 and has not been  
 2 notified by the board of trustees of the plan that  
 3 corrective action has restored compliance with such  
 4 requirements, and

5 “(2) the applicable authority determines that  
 6 there is a reasonable expectation that the plan will  
 7 continue to fail to meet the requirements of section  
 8 806,

9 the board of trustees of the plan shall, at the direction  
 10 of the applicable authority, terminate the plan and, in the  
 11 course of the termination, take such actions as the appli-  
 12 cable authority may require, including satisfying any  
 13 claims referred to in section 806(a)(2)(B)(iii) and recover-  
 14 ing for the plan any liability under subsection  
 15 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure  
 16 that the affairs of the plan will be, to the maximum extent  
 17 possible, wound up in a manner which will result in timely  
 18 provision of all benefits for which the plan is obligated.

19 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**  
 20 **VENT ASSOCIATION HEALTH PLANS PROVID-**  
 21 **ING HEALTH BENEFITS IN ADDITION TO**  
 22 **HEALTH INSURANCE COVERAGE.**

23 “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR  
 24 INSOLVENT PLANS.—Whenever the Secretary determines  
 25 that an association health plan which is or has been cer-

1   tified under this part and which is described in section  
2   806(a)(2) will be unable to provide benefits when due or  
3   is otherwise in a financially hazardous condition as defined  
4   in regulations of such Secretary, the Secretary shall, upon  
5   notice to the plan, apply to the appropriate United States  
6   district court for appointment of the Secretary as trustee  
7   to administer the plan for the duration of the insolvency.  
8   The plan may appear as a party and other interested per-  
9   sons may intervene in the proceedings at the discretion  
10   of the court. The court shall appoint such Secretary trust-  
11   ee if the court determines that the trusteeship is necessary  
12   to protect the interests of the participants and bene-  
13   ficiaries or providers of medical care or to avoid any un-  
14   reasonable deterioration of the financial condition of the  
15   plan. The trusteeship of such Secretary shall continue  
16   until the conditions described in the first sentence of this  
17   subsection are remedied or the plan is terminated.

18       “(b) POWERS AS TRUSTEE.—The Secretary, upon  
19   appointment as trustee under subsection (a), shall have  
20   the power—

21               “(1) to do any act authorized by the plan, this  
22       title, or other applicable provisions of law to be done  
23       by the plan administrator or any trustee of the plan,

1           “(2) to require the transfer of all (or any part)  
2           of the assets and records of the plan to the Sec-  
3           retary as trustee,

4           “(3) to invest any assets of the plan which the  
5           Secretary holds in accordance with the provisions of  
6           the plan, regulations of the Secretary, and applicable  
7           provisions of law,

8           “(4) to require the sponsor, the plan adminis-  
9           trator, any participating employer, and any employee  
10          organization representing plan participants to fur-  
11          nish any information with respect to the plan which  
12          the Secretary as trustee may reasonably need in  
13          order to administer the plan,

14          “(5) to collect for the plan any amounts due the  
15          plan and to recover reasonable expenses of the trust-  
16          eeship,

17          “(6) to commence, prosecute, or defend on be-  
18          half of the plan any suit or proceeding involving the  
19          plan,

20          “(7) to issue, publish, or file such notices, state-  
21          ments, and reports as may be required under regula-  
22          tions of the Secretary or by any order of the court,

23          “(8) to terminate the plan (or provide for its  
24          termination accordance with section 809(b)) and liq-  
25          uidate the plan assets, to restore the plan to the re-

1       sponsibility of the sponsor, or to continue the trust-  
2       eeship,

3           “(9) to provide for the enrollment of plan par-  
4       ticipants and beneficiaries under appropriate cov-  
5       erage options, and

6           “(10) to do such other acts as may be nec-  
7       essary to comply with this title or any order of the  
8       court and to protect the interests of plan partici-  
9       pants and beneficiaries and providers of medical  
10      care.

11      “(c) NOTICE OF APPOINTMENT.—As soon as prac-  
12     ticable after the Secretary’s appointment as trustee, the  
13     Secretary shall give notice of such appointment to—

14           “(1) the sponsor and plan administrator,

15           “(2) each participant,

16           “(3) each participating employer, and

17           “(4) if applicable, each employee organization  
18     which, for purposes of collective bargaining, rep-  
19     resents plan participants.

20      “(d) ADDITIONAL DUTIES.—Except to the extent in-  
21     consistent with the provisions of this title, or as may be  
22     otherwise ordered by the court, the Secretary, upon ap-  
23     pointment as trustee under this section, shall be subject  
24     to the same duties as those of a trustee under section 704

1 of title 11, United States Code, and shall have the duties  
2 of a fiduciary for purposes of this title.

3 “(e) OTHER PROCEEDINGS.—An application by the  
4 Secretary under this subsection may be filed notwithstand-  
5 ing the pendency in the same or any other court of any  
6 bankruptcy, mortgage foreclosure, or equity receivership  
7 proceeding, or any proceeding to reorganize, conserve, or  
8 liquidate such plan or its property, or any proceeding to  
9 enforce a lien against property of the plan.

10 “(f) JURISDICTION OF COURT.—

11 “(1) IN GENERAL.—Upon the filing of an appli-  
12 cation for the appointment as trustee or the issuance  
13 of a decree under this section, the court to which the  
14 application is made shall have exclusive jurisdiction  
15 of the plan involved and its property wherever lo-  
16 cated with the powers, to the extent consistent with  
17 the purposes of this section, of a court of the United  
18 States having jurisdiction over cases under chapter  
19 11 of title 11, United States Code. Pending an adju-  
20 dication under this section such court shall stay, and  
21 upon appointment by it of the Secretary as trustee,  
22 such court shall continue the stay of, any pending  
23 mortgage foreclosure, equity receivership, or other  
24 proceeding to reorganize, conserve, or liquidate the  
25 plan, the sponsor, or property of such plan or spon-



1       sor, and any other suit against any receiver, con-  
2       servator, or trustee of the plan, the sponsor, or  
3       property of the plan or sponsor. Pending such adju-  
4       dication and upon the appointment by it of the Sec-  
5       retary as trustee, the court may stay any proceeding  
6       to enforce a lien against property of the plan or the  
7       sponsor or any other suit against the plan or the  
8       sponsor.

9           “(2) VENUE.—An action under this section  
10       may be brought in the judicial district where the  
11       sponsor or the plan administrator resides or does  
12       business or where any asset of the plan is situated.  
13       A district court in which such action is brought may  
14       issue process with respect to such action in any  
15       other judicial district.

16       “(g) PERSONNEL.—In accordance with regulations of  
17       the Secretary, the Secretary shall appoint, retain, and  
18       compensate accountants, actuaries, and other professional  
19       service personnel as may be necessary in connection with  
20       the Secretary’s service as trustee under this section.

21       **“SEC. 811. STATE ASSESSMENT AUTHORITY.**

22       “(a) IN GENERAL.—Notwithstanding section 514, a  
23       State may impose by law a contribution tax on an associa-  
24       tion health plan described in section 806(a)(2), if the plan  
25       commenced operations in such State after the date of the

1 enactment of the Small Business Affordable Health Cov-  
2 erage Act of 1998.

3 “(b) CONTRIBUTION TAX.—For purposes of this sec-  
4 tion, the term ‘contribution tax’ imposed by a State on  
5 an association health plan means any tax imposed by such  
6 State if—

7 “(1) such tax is computed by applying a rate to  
8 the amount of premiums or contributions, with re-  
9 spect to individuals covered under the plan who are  
10 residents of such State, which are received by the  
11 plan from participating employers located in such  
12 State or from such individuals,

13 “(2) the rate of such tax does not exceed the  
14 rate of any tax imposed by such State on premiums  
15 or contributions received by insurers or health main-  
16 tenance organizations for health insurance coverage  
17 offered in such State in connection with a group  
18 health plan,

19 “(3) such tax is otherwise nondiscriminatory,  
20 and

21 “(4) the amount of any such tax assessed on  
22 the plan is reduced by the amount of any tax or as-  
23 sessment otherwise imposed by the State on pre-  
24 miums, contributions, or both received by insurers or  
25 health maintenance organizations for health insur-

1       ance coverage, aggregate excess/stop loss insurance  
 2       (as defined in section 806(g)(1)), specific excess/stop  
 3       loss insurance (as defined in section 806(g)(2)),  
 4       other insurance related to the provision of medical  
 5       care under the plan, or any combination thereof pro-  
 6       vided by such insurers or health maintenance organi-  
 7       zations in such State in connection with such plan.

8       **“SEC. 812. SPECIAL RULES FOR CHURCH PLANS.**

9       “(a) ELECTION FOR CHURCH PLANS.—Notwith-  
 10       standing section 4(b)(2), if a church, a convention or asso-  
 11       ciation of churches, or an organization described in section  
 12       3(33)(C)(i) maintains a church plan which is a group  
 13       health plan (as defined in section 733(a)(1)), and such  
 14       church, convention, association, or organization makes an  
 15       election with respect to such plan under this subsection  
 16       (in such form and manner as the Secretary may by regula-  
 17       tion prescribe), then the provisions of this section shall  
 18       apply to such plan, with respect to benefits provided under  
 19       such plan consisting of medical care, as if section 4(b)(2)  
 20       did not contain an exclusion for church plans. Nothing in  
 21       this subsection shall be construed to render any other sec-  
 22       tion of this title applicable to church plans, except to the  
 23       extent that such other section is incorporated by reference  
 24       in this section.

25       “(b) EFFECT OF ELECTION.—

1           “(1) PREEMPTION OF STATE INSURANCE LAWS  
2       REGULATING COVERED CHURCH PLANS.—Subject to  
3       paragraphs (2) and (3), this section shall supersede  
4       any and all State laws which regulate insurance in-  
5       sofar as they may now or hereafter regulate church  
6       plans to which this section applies or trusts estab-  
7       lished under such church plans.

8           “(2) GENERAL STATE INSURANCE REGULATION  
9       UNAFFECTED.—

10           “(A) IN GENERAL.—Except as provided in  
11       subparagraph (B) and paragraph (3), nothing  
12       in this section shall be construed to exempt or  
13       relieve any person from any provision of State  
14       law which regulates insurance.

15           “(B) CHURCH PLANS NOT TO BE DEEMED  
16       INSURANCE COMPANIES OR INSURERS.—Neither  
17       a church plan to which this section applies, nor  
18       any trust established under such a church plan,  
19       shall be deemed to be an insurance company or  
20       other insurer or to be engaged in the business  
21       of insurance for purposes of any State law pur-  
22       porting to regulate insurance companies or in-  
23       surance contracts.

24           “(3) PREEMPTION OF CERTAIN STATE LAWS  
25       RELATING TO PREMIUM RATE REGULATION AND

1 BENEFIT MANDATES.—The provisions of subsections  
2 (a)(2)(B) and (b) of section 805 shall apply with re-  
3 spect to a church plan to which this section applies  
4 in the same manner and to the same extent as such  
5 provisions apply with respect to association health  
6 plans.

7 “(4) DEFINITIONS.—For purposes of this sub-  
8 section—

9 “(A) STATE LAW.—The term ‘State law’  
10 includes all laws, decisions, rules, regulations,  
11 or other State action having the effect of law,  
12 of any State. A law of the United States appli-  
13 cable only to the District of Columbia shall be  
14 treated as a State law rather than a law of the  
15 United States.

16 “(B) STATE.—The term ‘State’ includes a  
17 State, any political subdivision thereof, or any  
18 agency or instrumentality of either, which pur-  
19 ports to regulate, directly or indirectly, the  
20 terms and conditions of church plans covered by  
21 this section.

22 “(c) REQUIREMENTS FOR COVERED CHURCH  
23 PLANS.—

24 “(1) FIDUCIARY RULES AND EXCLUSIVE PUR-  
25 POSE.—A fiduciary shall discharge his duties with

1       respect to a church plan to which this section ap-  
2       plies—

3               “(A) for the exclusive purpose of:

4                       “(i) providing benefits to participants  
5                       and their beneficiaries; and

6                       “(ii) defraying reasonable expenses of  
7                       administering the plan;

8               “(B) with the care, skill, prudence and dili-  
9               gence under the circumstances then prevailing  
10              that a prudent man acting in a like capacity  
11              and familiar with such matters would use in the  
12              conduct of an enterprise of a like character and  
13              with like aims; and

14              “(C) in accordance with the documents  
15              and instruments governing the plan.

16       The requirements of this paragraph shall not be  
17       treated as not satisfied solely because the plan as-  
18       sets are commingled with other church assets, to the  
19       extent that such plan assets are separately ac-  
20       counted for.

21              “(2) CLAIMS PROCEDURE.—In accordance with  
22       regulations of the Secretary, every church plan to  
23       which this section applies shall—

24                       “(A) provide adequate notice in writing to  
25                       any participant or beneficiary whose claim for

1           benefits under the plan has been denied, setting  
2           forth the specific reasons for such denial, writ-  
3           ten in a manner calculated to be understood by  
4           the participant;

5           “(B) afford a reasonable opportunity to  
6           any participant whose claim for benefits has  
7           been denied for a full and fair review by the ap-  
8           propriate fiduciary of the decision denying the  
9           claim; and

10           “(C) provide a written statement to each  
11           participant describing the procedures estab-  
12           lished pursuant to this paragraph.

13           “(3) ANNUAL STATEMENTS.—In accordance  
14           with regulations of the Secretary, every church plan  
15           to which this section applies shall file with the Sec-  
16           retary an annual statement—

17           “(A) stating the names and addresses of  
18           the plan and of the church, convention, or asso-  
19           ciation maintaining the plan (and its principal  
20           place of business);

21           “(B) certifying that it is a church plan to  
22           which this section applies and that it complies  
23           with the requirements of paragraphs (1) and  
24           (2);

1           “(C) identifying the States in which par-  
2           ticipants and beneficiaries under the plan are or  
3           likely will be located during the 1-year period  
4           covered by the statement; and

5           “(D) containing a copy of a statement of  
6           actuarial opinion signed by a qualified actuary  
7           that the plan maintains capital, reserves, insur-  
8           ance, other financial arrangements, or any com-  
9           bination thereof adequate to enable the plan to  
10          fully meet all of its financial obligations on a  
11          timely basis.

12          “(4) DISCLOSURE.—At the time that the an-  
13          nual statement is filed by a church plan with the  
14          Secretary pursuant to paragraph (3), a copy of such  
15          statement shall be made available by the Secretary  
16          to the State insurance commissioner (or similar offi-  
17          cial) of any State. The name of each church plan  
18          and sponsoring organization filing an annual state-  
19          ment in compliance with paragraph (3) shall be pub-  
20          lished annually in the Federal Register.

21          “(c) ENFORCEMENT.—The Secretary may enforce  
22          the provisions of this section in a manner consistent with  
23          section 502, to the extent applicable with respect to ac-  
24          tions under section 502(a)(5), and with section 3(33)(D),  
25          except that, other than for the purpose of seeking a tem-



1 porary restraining order, a civil action may be brought  
2 with respect to the plan's failure to meet any requirement  
3 of this section only if the plan fails to correct its failure  
4 within the correction period described in section 3(33)(D).  
5 The other provisions of part 5 (except sections 501(a),  
6 503, 512, 514, and 515) shall apply with respect to the  
7 enforcement and administration of this section.

8 “(d) DEFINITIONS AND OTHER RULES.—For pur-  
9 poses of this section—

10 “(1) IN GENERAL.—Except as otherwise pro-  
11 vided in this section, any term used in this section  
12 which is defined in any provision of this title shall  
13 have the definition provided such term by such pro-  
14 vision.

15 “(2) SEMINARY STUDENTS.—Seminary students  
16 who are enrolled in an institution of higher learning  
17 described in section 3(33)(C)(iv) and who are treat-  
18 ed as participants under the terms of a church plan  
19 to which this section applies shall be deemed to be  
20 employees as defined in section 3(6) if the number  
21 of such students constitutes an insignificant portion  
22 of the total number of individuals who are treated  
23 as participants under the terms of the plan.

24 **“SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.**

25 “(a) DEFINITIONS.—For purposes of this part—

1           “(1) GROUP HEALTH PLAN.—The term ‘group  
2       health plan’ has the meaning provided in section  
3       733(a)(1) (after applying subsection (b) of this sec-  
4       tion).

5           “(2) MEDICAL CARE.—The term ‘medical care’  
6       has the meaning provided in section 733(a)(2).

7           “(3) HEALTH INSURANCE COVERAGE.—The  
8       term ‘health insurance coverage’ has the meaning  
9       provided in section 733(b)(1).

10          “(4) HEALTH INSURANCE ISSUER.—The term  
11       ‘health insurance issuer’ has the meaning provided  
12       in section 733(b)(2).

13          “(5) APPLICABLE AUTHORITY.—

14               “(A) IN GENERAL.—Except as provided in  
15       subparagraph (B), the term ‘applicable author-  
16       ity’ means, in connection with an association  
17       health plan—

18                   “(i) the State recognized pursuant to  
19       subsection (c) of section 506 as the State  
20       to which authority has been delegated in  
21       connection with such plan, or

22                   “(ii) if there if no State referred to in  
23       clause (i), the Secretary.

24          “(B) EXCEPTIONS.—

1                   “(i) JOINT AUTHORITIES.—Where  
2                   such term appears in section 808(3), sec-  
3                   tion 807(e) (in the first instance), section  
4                   809(a) (in the second instance), section  
5                   809(a) (in the fourth instance), and sec-  
6                   tion 809(b)(1), such term means, in con-  
7                   nection with an association health plan, the  
8                   Secretary and the State referred to in sub-  
9                   paragraph (A)(i) (if any) in connection  
10                  with such plan.

11                  “(ii) REGULATORY AUTHORITIES.—  
12                  Where such term appears in section 802(a)  
13                  (in the first instance), section 802(d), sec-  
14                  tion 802(e), section 803(d), section  
15                  805(a)(5), section 806(a)(2), section  
16                  806(b), section 806(c), section 806(d),  
17                  paragraphs (1)(A) and (2)(A) of section  
18                  806(g), section 806(h), section 806(i), sec-  
19                  tion 807(a) (in the second instance), sec-  
20                  tion 807(b), section 807(d), section 807(e)  
21                  (in the second instance), section 808 (in  
22                  the matter after paragraph (3)), and sec-  
23                  tion 809(a) (in the third instance), such  
24                  term means, in connection with an associa-  
25                  tion health plan, the Secretary.

1           “(6) HEALTH STATUS-RELATED FACTOR.—The  
2           term ‘health status-related factor’ has the meaning  
3           provided in section 733(d)(2).

4           “(7) INDIVIDUAL MARKET.—

5                   “(A) IN GENERAL.—The term ‘individual  
6           market’ means the market for health insurance  
7           coverage offered to individuals other than in  
8           connection with a group health plan.

9                   “(B) TREATMENT OF VERY SMALL  
10           GROUPS.—

11                           “(i) IN GENERAL.—Subject to clause  
12                           (ii), such term includes coverage offered in  
13                           connection with a group health plan that  
14                           has fewer than 2 participants as current  
15                           employees or participants described in sec-  
16                           tion 732(d)(3) on the first day of the plan  
17                           year.

18                           “(ii) STATE EXCEPTION.—Clause (i)  
19                           shall not apply in the case of health insur-  
20                           ance coverage offered in a State if such  
21                           State regulates the coverage described in  
22                           such clause in the same manner and to the  
23                           same extent as coverage in the small group  
24                           market (as defined in section 2791(e)(5) of

1 the Public Health Service Act) is regulated  
2 by such State.

3 “(8) PARTICIPATING EMPLOYER.—The term  
4 ‘participating employer’ means, in connection with  
5 an association health plan, any employer, if any indi-  
6 vidual who is an employee of such employer, a part-  
7 ner in such employer, or a self-employed individual  
8 who is such employer (or any dependent, as defined  
9 under the terms of the plan, of such individual) is  
10 or was covered under such plan in connection with  
11 the status of such individual as such an employee,  
12 partner, or self-employed individual in relation to the  
13 plan.

14 “(9) APPLICABLE STATE AUTHORITY.—The  
15 term ‘applicable State authority’ means, with respect  
16 to a health insurance issuer in a State, the State in-  
17 surance commissioner or official or officials des-  
18 ignated by the State to enforce the requirements of  
19 title XXVII of the Public Health Service Act for the  
20 State involved with respect to such issuer.

21 “(10) QUALIFIED ACTUARY.—The term ‘quali-  
22 fied actuary’ means an individual who is a member  
23 of the American Academy of Actuaries or meets  
24 such reasonable standards and qualifications as the  
25 Secretary may provide by regulation.

1           “(11) AFFILIATED MEMBER.—The term ‘affili-  
2       ated member’ means, in connection with a sponsor,  
3       a person eligible to be a member of the sponsor or,  
4       in the case of a sponsor with member associations,  
5       a person who is a member, or is eligible to be a  
6       member, of a member association.

7           “(12) LARGE EMPLOYER.—The term ‘large em-  
8       ployer’ means, in connection with a group health  
9       plan with respect to a plan year, an employer who  
10      employed an average of at least 51 employees on  
11      business days during the preceding calendar year  
12      and who employs at least 2 employees on the first  
13      day of the plan year.

14          “(13) SMALL EMPLOYER.—The term ‘small em-  
15      ployer’ means, in connection with a group health  
16      plan with respect to a plan year, an employer who  
17      is not a large employer.

18          “(b) RULES OF CONSTRUCTION.—

19               “(1) EMPLOYERS AND EMPLOYEES.—For pur-  
20      poses of determining whether a plan, fund, or pro-  
21      gram is an employee welfare benefit plan which is an  
22      association health plan, and for purposes of applying  
23      this title in connection with such plan, fund, or pro-  
24      gram so determined to be such an employee welfare  
25      benefit plan—

1           “(A) in the case of a partnership, the term  
2           ‘employer’ (as defined in section (3)(5)) in-  
3           cludes the partnership in relation to the part-  
4           ners, and the term ‘employee’ (as defined in  
5           section (3)(6)) includes any partner in relation  
6           to the partnership, and

7           “(B) in the case of a self-employed individ-  
8           ual, the term ‘employer’ (as defined in section  
9           3(5)) and the term ‘employee’ (as defined in  
10          section 3(6)) shall include such individual.

11          “(2) PLANS, FUNDS, AND PROGRAMS TREATED  
12          AS EMPLOYEE WELFARE BENEFIT PLANS.—In the  
13          case of any plan, fund, or program which was estab-  
14          lished or is maintained for the purpose of providing  
15          medical care (through the purchase of insurance or  
16          otherwise) for employees (or their dependents) cov-  
17          ered thereunder and which demonstrates to the Sec-  
18          retary that all requirements for certification under  
19          this part would be met with respect to such plan,  
20          fund, or program if such plan, fund, or program  
21          were a group health plan, such plan, fund, or pro-  
22          gram shall be treated for purposes of this title as an  
23          employee welfare benefit plan on and after the date  
24          of such demonstration.”.

1 (b) CONFORMING AMENDMENTS TO PREEMPTION  
2 RULES.—

3 (1) Section 514(b)(6) of such Act (29 U.S.C.  
4 1144(b)(6)) is amended by adding at the end the  
5 following new subparagraph:

6 “(E) The preceding subparagraphs of this paragraph  
7 do not apply with respect to any State law in the case  
8 of an association health plan which is certified under part  
9 8.”.

10 (2) Section 514 of such Act (29 U.S.C. 1144)  
11 is amended—

12 (A) in subsection (b)(4), by striking “Sub-  
13 section (a)” and inserting “Subsections (a) and  
14 (d)”;

15 (B) in subsection (b)(5), by striking “sub-  
16 section (a)” in subparagraph (A) and inserting  
17 “subsection (a) of this section and subsections  
18 (a)(2)(B) and (b) of section 805”, and by strik-  
19 ing “subsection (a)” in subparagraph (B) and  
20 inserting “subsection (a) of this section or sub-  
21 section (a)(2)(B) or (b) of section 805”;

22 (C) by redesignating subsection (d) as sub-  
23 section (e); and

24 (D) by inserting after subsection (c) the  
25 following new subsection:



1       “(d)(1) Except as provided in subsection (b)(4), the  
2 provisions of this title shall supersede any and all State  
3 laws insofar as they may now or hereafter preclude, or  
4 have the effect of precluding, a health insurance issuer  
5 from offering health insurance coverage in connection with  
6 an association health plan which is certified under part  
7 8.

8       “(2) Except as provided in paragraphs (4) and (5)  
9 of subsection (b) of this section—

10           “(A) In any case in which health insurance cov-  
11 erage of any policy type is offered under an associa-  
12 tion health plan certified under part 8 to a partici-  
13 pating employer operating in such State, the provi-  
14 sions of this title shall supersede any and all laws  
15 of such State insofar as they may preclude a health  
16 insurance issuer from offering health insurance cov-  
17 erage of the same policy type to other employers op-  
18 erating in the State which are eligible for coverage  
19 under such association health plan, whether or not  
20 such other employers are participating employers in  
21 such plan.

22           “(B) In any case in which health insurance cov-  
23 erage of any policy type is offered under an associa-  
24 tion health plan in a State and the filing, with the  
25 applicable State authority, of the policy form in con-

1        nection with such policy type is approved by such  
 2        State authority, the provisions of this title shall su-  
 3        percede any and all laws of any other State in which  
 4        health insurance coverage of such type is offered, in-  
 5        sofar as they may preclude, upon the filing in the  
 6        same form and manner of such policy form with the  
 7        applicable State authority in such other State, the  
 8        approval of the filing in such other State.

9        “(3) For additional provisions relating to association  
 10      health plans, see subsections (a)(2)(B) and (b) of section  
 11      805.

12       “(4) For purposes of this subsection, the term ‘asso-  
 13      ciation health plan’ has the meaning provided in section  
 14      801(a), and the terms ‘health insurance coverage’, ‘par-  
 15      ticipating employer’, and ‘health insurance issuer’ have  
 16      the meanings provided such terms in section 811, respec-  
 17      tively.”.

18                (3) Section 514(b)(6)(A) of such Act (29  
 19      U.S.C. 1144(b)(6)(A)) is amended—

20                        (A) in clause (i)(II), by striking “and” at  
 21                        the end;

22                        (B) in clause (ii), by inserting “and which  
 23                        does not provide medical care (within the mean-  
 24                        ing of section 733(a)(2)),” after “arrange-

1           ment,” and by striking “title.” and inserting  
2           “title, and”; and

3           (C) by adding at the end the following new  
4           clause:

5           “(iii) subject to subparagraph (E), in the case  
6           of any other employee welfare benefit plan which is  
7           a multiple employer welfare arrangement and which  
8           provides medical care (within the meaning of section  
9           733(a)(2)), any law of any State which regulates in-  
10          surance may apply.”.

11          (4) Section 514(e) of such Act (as redesignated  
12          by paragraph (2)(C)) is amended—

13               (A) by striking “Nothing” and inserting  
14               “(1) Except as provided in paragraph (2), noth-  
15               ing”; and

16               (B) by adding at the end the following new  
17               paragraph:

18           “(2) Nothing in any other provision of law enacted  
19           on or after the date of the enactment of the Patient Pro-  
20           tection Act of 1998 shall be construed to alter, amend,  
21           modify, invalidate, impair, or supersede any provision of  
22           this title, except by specific cross-reference to the affected  
23           section.”.

24          (c) PLAN SPONSOR.—Section 3(16)(B) of such Act  
25          (29 U.S.C. 102(16)(B)) is amended by adding at the end

1 the following new sentence: “Such term also includes a  
 2 person serving as the sponsor of an association health plan  
 3 under part 8.”.

4 (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-  
 5 LATED TO SELF-INSURED AND FULLY INSURED OPTIONS  
 6 UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)  
 7 of such Act (29 U.S.C. 102(b)) is amended by adding at  
 8 the end the following: “An association health plan shall  
 9 include in its summary plan description, in connection  
 10 with each benefit option, a description of the form of sol-  
 11 vency or guarantee fund protection secured pursuant to  
 12 this Act or applicable State law, if any.”.

13 (e) SAVINGS CLAUSE.—Section 731(c) of such Act is  
 14 amended by inserting “or part 8” after “this part”.

15 (f) CLERICAL AMENDMENT.—The table of contents  
 16 in section 1 of the Employee Retirement Income Security  
 17 Act of 1974 is amended by inserting after the item relat-  
 18 ing to section 734 the following new items:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“Sec. 801. Association health plans.

“Sec. 802. Certification of association health plans.

“Sec. 803. Requirements relating to sponsors and boards of trustees.

“Sec. 804. Participation and coverage requirements.

“Sec. 805. Other requirements relating to plan documents, contribution rates,  
 and benefit options.

“Sec. 806. Maintenance of reserves and provisions for solvency for plans pro-  
 viding health benefits in addition to health insurance coverage.

“Sec. 807. Requirements for application and related requirements.

“Sec. 808. Notice requirements for voluntary termination.

“Sec. 809. Corrective actions and mandatory termination.

“Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

“Sec. 811. State assessment authority.

“Sec. 812. Special rules for church plans.

“Sec. 813. Definitions and rules of construction.”.

1   **SEC. 1303. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
 2                           **PLOYER ARRANGEMENTS.**

3           Section 3(40)(B) of the Employee Retirement Income  
 4   Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-  
 5   ed—

6                   (1) in clause (i), by inserting “for any plan year  
 7           of any such plan, or any fiscal year of any such  
 8           other arrangement;” after “single employer”, and by  
 9           inserting “during such year or at any time during  
 10          the preceding 1-year period” after “control group”;

11                  (2) in clause (iii)—

12                   (A) by striking “common control shall not  
 13           be based on an interest of less than 25 percent”  
 14           and inserting “an interest of greater than 25  
 15           percent may not be required as the minimum  
 16           interest necessary for common control”; and

17                   (B) by striking “similar to” and inserting  
 18           “consistent and coextensive with”;

19                  (3) by redesignating clauses (iv) and (v) as  
 20          clauses (v) and (vi), respectively; and

21                  (4) by inserting after clause (iii) the following  
 22          new clause:

1           “(iv) in determining, after the application of  
 2           clause (i), whether benefits are provided to employ-  
 3           ees of two or more employers, the arrangement shall  
 4           be treated as having only 1 participating employer  
 5           if, after the application of clause (i), the number of  
 6           individuals who are employees and former employees  
 7           of any one participating employer and who are cov-  
 8           ered under the arrangement is greater than 75 per-  
 9           cent of the aggregate number of all individuals who  
 10          are employees or former employees of participating  
 11          employers and who are covered under the arrange-  
 12          ment,”.

13 **SEC. 1304. CLARIFICATION OF TREATMENT OF CERTAIN**  
 14                   **COLLECTIVELY    BARGAINED    ARRANGE-**  
 15                   **MENTS.**

16           (a) IN GENERAL.—Section 3(40)(A)(i) of the Em-  
 17          ployee Retirement Income Security Act of 1974 (29  
 18          U.S.C. 1002(40)(A)(i)) is amended to read as follows:

19           “(i)(I) under or pursuant to one or more collec-  
 20          tive bargaining agreements which are reached pursu-  
 21          ant to collective bargaining described in section 8(d)  
 22          of the National Labor Relations Act (29 U.S.C.  
 23          158(d)) or paragraph Fourth of section 2 of the  
 24          Railway Labor Act (45 U.S.C. 152, paragraph  
 25          Fourth) or which are reached pursuant to labor-

1 management negotiations under similar provisions of  
2 State public employee relations laws, and (II) in ac-  
3 cordance with subparagraphs (C), (D), and (E),”.

4 (b) LIMITATIONS.—Section 3(40) of such Act (29  
5 U.S.C. 1002(40)) is amended by adding at the end the  
6 following new subparagraphs:

7 “(C) For purposes of subparagraph (A)(i)(II), a plan  
8 or other arrangement shall be treated as established or  
9 maintained in accordance with this subparagraph only if  
10 the following requirements are met:

11 “(i) The plan or other arrangement, and the  
12 employee organization or any other entity sponsoring  
13 the plan or other arrangement, do not—

14 “(I) utilize the services of any licensed in-  
15 surance agent or broker for soliciting or enroll-  
16 ing employers or individuals as participating  
17 employers or covered individuals under the plan  
18 or other arrangement; or

19 “(II) pay a commission or any other type  
20 of compensation to a person, other than a full  
21 time employee of the employee organization (or  
22 a member of the organization to the extent pro-  
23 vided in regulations of the Secretary), that is  
24 related either to the volume or number of em-  
25 ployers or individuals solicited or enrolled as

1 participating employers or covered individuals  
2 under the plan or other arrangement, or to the  
3 dollar amount or size of the contributions made  
4 by participating employers or covered individ-  
5 uals to the plan or other arrangement;

6 except to the extent that the services used by the  
7 plan, arrangement, organization, or other entity con-  
8 sist solely of preparation of documents necessary for  
9 compliance with the reporting and disclosure re-  
10 quirements of part 1 or administrative, investment,  
11 or consulting services unrelated to solicitation or en-  
12 rollment of covered individuals.

13 “(ii) As of the end of the preceding plan year,  
14 the number of covered individuals under the plan or  
15 other arrangement who are identified to the plan or  
16 arrangement and who are neither—

17 “(I) employed within a bargaining unit  
18 covered by any of the collective bargaining  
19 agreements with a participating employer (nor  
20 covered on the basis of an individual’s employ-  
21 ment in such a bargaining unit); nor

22 “(II) present employees (or former employ-  
23 ees who were covered while employed) of the  
24 sponsoring employee organization, of an em-  
25 ployer who is or was a party to any of the col-



1           lective bargaining agreements, or of the plan or  
2           other arrangement or a related plan or arrange-  
3           ment (nor covered on the basis of such present  
4           or former employment);

5           does not exceed 15 percent of the total number of  
6           individuals who are covered under the plan or ar-  
7           rangement and who are present or former employees  
8           who are or were covered under the plan or arrange-  
9           ment pursuant to a collective bargaining agreement  
10          with a participating employer. The requirements of  
11          the preceding provisions of this clause shall be treat-  
12          ed as satisfied if, as of the end of the preceding plan  
13          year, such covered individuals are comprised solely  
14          of individuals who were covered individuals under  
15          the plan or other arrangement as of the date of the  
16          enactment of the Small Business Affordable Health  
17          Coverage Act of 1998 and, as of the end of the pre-  
18          ceding plan year, the number of such covered indi-  
19          viduals does not exceed 25 percent of the total num-  
20          ber of present and former employees enrolled under  
21          the plan or other arrangement.

22               “(iii) The employee organization or other entity  
23           sponsoring the plan or other arrangement certifies  
24           to the Secretary each year, in a form and manner  
25           which shall be prescribed in regulations of the Sec-

1       retary that the plan or other arrangement meets the  
2       requirements of clauses (i) and (ii).

3       “(D) For purposes of subparagraph (A)(i)(II), a plan  
4 or arrangement shall be treated as established or main-  
5 tained in accordance with this subparagraph only if—

6               “(i) all of the benefits provided under the plan  
7       or arrangement consist of health insurance coverage;  
8       or

9               “(ii)(I) the plan or arrangement is a multiem-  
10      ployer plan; and

11              “(II) the requirements of clause (B) of the pro-  
12      viso to clause (5) of section 302(c) of the Labor  
13      Management Relations Act, 1947 (29 U.S.C.  
14      186(c)) are met with respect to such plan or other  
15      arrangement.

16      “(E) For purposes of subparagraph (A)(i)(II), a plan  
17 or arrangement shall be treated as established or main-  
18 tained in accordance with this subparagraph only if—

19              “(i) the plan or arrangement is in effect as of  
20      the date of the enactment of the Small Business Af-  
21      fordable Health Coverage Act of 1998, or

22              “(ii) the employee organization or other entity  
23      sponsoring the plan or arrangement—

24                      “(I) has been in existence for at least 3  
25      years or is affiliated with another employee or-

1           ganization which has been in existence for at  
2           least 3 years, or

3           “(II) demonstrates to the satisfaction of  
4           the Secretary that the requirements of subpara-  
5           graphs (C) and (D) are met with respect to the  
6           plan or other arrangement.”.

7           (c) CONFORMING AMENDMENTS TO DEFINITIONS OF  
8   PARTICIPANT AND BENEFICIARY.—Section 3(7) of such  
9   Act (29 U.S.C. 1002(7)) is amended by adding at the end  
10   the following new sentence: “Such term includes an indi-  
11   vidual who is a covered individual described in paragraph  
12   (40)(C)(ii).”.

13   **SEC. 1305. ENFORCEMENT PROVISIONS RELATING TO ASSO-**  
14                           **CIATION HEALTH PLANS.**

15           (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL  
16   MISREPRESENTATIONS.—Section 501 of the Employee  
17   Retirement Income Security Act of 1974 (29 U.S.C. 1131)  
18   is amended—

19           (1) by inserting “(a)” after “SEC. 501.”; and

20           (2) by adding at the end the following new sub-  
21   section:

22           “(b) Any person who, either willfully or with willful  
23   blindness, falsely represents, to any employee, any employ-  
24   ee’s beneficiary, any employer, the Secretary, or any State,  
25   a plan or other arrangement established or maintained for

1 the purpose of offering or providing any benefit described  
 2 in section 3(1) to employees or their beneficiaries as—

3 “(1) being an association health plan which has  
 4 been certified under part 8;

5 “(2) having been established or maintained  
 6 under or pursuant to one or more collective bargain-  
 7 ing agreements which are reached pursuant to col-  
 8 lective bargaining described in section 8(d) of the  
 9 National Labor Relations Act (29 U.S.C. 158(d)) or  
 10 paragraph Fourth of section 2 of the Railway Labor  
 11 Act (45 U.S.C. 152, paragraph Fourth) or which are  
 12 reached pursuant to labor-management negotiations  
 13 under similar provisions of State public employee re-  
 14 lations laws; or

15 “(3) being a plan or arrangement with respect  
 16 to which the requirements of subparagraph (C), (D),  
 17 or (E) of section 3(40) are met;

18 shall, upon conviction, be imprisoned not more than five  
 19 years, be fined under title 18, United States Code, or  
 20 both.”.

21 (b) CEASE ACTIVITIES ORDERS.—Section 502 of  
 22 such Act (29 U.S.C. 1132) is amended by adding at the  
 23 end the following new subsection:

24 “(n)(1) Subject to paragraph (2), upon application  
 25 by the Secretary showing the operation, promotion, or

1 marketing of an association health plan (or similar ar-  
2 rangement providing benefits consisting of medical care  
3 (as defined in section 733(a)(2))) that—

4 “(A) is not certified under part 8, is subject  
5 under section 514(b)(6) to the insurance laws of any  
6 State in which the plan or arrangement offers or  
7 provides benefits, and is not licensed, registered, or  
8 otherwise approved under the insurance laws of such  
9 State; or

10 “(B) is an association health plan certified  
11 under part 8 and is not operating in accordance with  
12 the requirements under part 8 for such certification,  
13 a district court of the United States shall enter an order  
14 requiring that the plan or arrangement cease activities.

15 “(2) Paragraph (1) shall not apply in the case of an  
16 association health plan or other arrangement if the plan  
17 or arrangement shows that—

18 “(A) all benefits under it referred to in para-  
19 graph (1) consist of health insurance coverage; and

20 “(B) with respect to each State in which the  
21 plan or arrangement offers or provides benefits, the  
22 plan or arrangement is operating in accordance with  
23 applicable State laws that are not superseded under  
24 section 514.

1       “(3) The court may grant such additional equitable  
2 relief, including any relief available under this title, as it  
3 deems necessary to protect the interests of the public and  
4 of persons having claims for benefits against the plan.”.

5       (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—  
6 Section 503 of such Act (29 U.S.C. 1133) (as amended  
7 by title I) is amended by adding at the end the following  
8 new subsection:

9       “(c) ASSOCIATION HEALTH PLANS.—The terms of  
10 each association health plan which is or has been certified  
11 under part 8 shall require the board of trustees or the  
12 named fiduciary (as applicable) to ensure that the require-  
13 ments of this section are met in connection with claims  
14 filed under the plan.”.

15 **SEC. 1306. COOPERATION BETWEEN FEDERAL AND STATE**  
16 **AUTHORITIES.**

17       Section 506 of the Employee Retirement Income Se-  
18 curity Act of 1974 (29 U.S.C. 1136) is amended by adding  
19 at the end the following new subsection:

20       “(c) RESPONSIBILITY OF STATES WITH RESPECT TO  
21 ASSOCIATION HEALTH PLANS.—

22               “(1) AGREEMENTS WITH STATES.—A State  
23 may enter into an agreement with the Secretary for  
24 delegation to the State of some or all of—

1           “(A) the Secretary’s authority under sec-  
2           tions 502 and 504 to enforce the requirements  
3           for certification under part 8,

4           “(B) the Secretary’s authority to certify  
5           association health plans under part 8 in accord-  
6           ance with regulations of the Secretary applica-  
7           ble to certification under part 8, or

8           “(C) any combination of the Secretary’s  
9           authority authorized to be delegated under sub-  
10          paragraphs (A) and (B).

11          “(2) DELEGATIONS.—Any department, agency,  
12          or instrumentality of a State to which authority is  
13          delegated pursuant to an agreement entered into  
14          under this paragraph may, if authorized under State  
15          law and to the extent consistent with such agree-  
16          ment, exercise the powers of the Secretary under  
17          this title which relate to such authority.

18          “(3) RECOGNITION OF PRIMARY DOMICILE  
19          STATE.—In entering into any agreement with a  
20          State under subparagraph (A), the Secretary shall  
21          ensure that, as a result of such agreement and all  
22          other agreements entered into under subparagraph  
23          (A), only one State will be recognized, with respect  
24          to any particular association health plan, as the  
25          State to which all authority has been delegated pur-

1        suant to such agreements in connection with such  
2        plan. In carrying out this paragraph, the Secretary  
3        shall take into account the places of residence of the  
4        participants and beneficiaries under the plan and the  
5        State in which the trust is maintained.”.

6    **SEC. 1307. EFFECTIVE DATE AND TRANSITIONAL AND**  
7                    **OTHER RULES.**

8        (a) **EFFECTIVE DATE.**—The amendments made by  
9        sections 1302, 1305, and 1306 shall take effect on Janu-  
10       ary 1, 2000. The amendments made by sections 1303 and  
11       1304 shall take effect on the date of the enactment of  
12       this Act. The Secretary of Labor shall first issue all regu-  
13       lations necessary to carry out the amendments made by  
14       this Act before January 1, 2000.

15       (b) **EXCEPTION.**—Section 801(a)(2) of the Employee  
16       Retirement Income Security Act of 1974 (added by section  
17       1302) does not apply in connection with an association  
18       health plan (certified under part 8 of subtitle B of title  
19       I of such Act) existing on April 1, 1997, if no benefits  
20       provided thereunder as of the date of the enactment of  
21       this Act consist of health insurance coverage (as defined  
22       in section 733(b)(1) of such Act).

23       (c) **TREATMENT OF CERTAIN EXISTING HEALTH**  
24       **BENEFITS PROGRAMS.**—



1           (1) IN GENERAL.—In any case in which, as of  
2           the date of the enactment of this Act, an arrange-  
3           ment is maintained in a State for the purpose of  
4           providing benefits consisting of medical care for the  
5           employees and beneficiaries of its participating em-  
6           ployers, at least 200 participating employers make  
7           contributions to such arrangement, such arrange-  
8           ment has been in existence for at least 10 years, and  
9           such arrangement is licensed under the laws of one  
10          or more States to provide such benefits to its par-  
11          ticipating employers, upon the filing with the appli-  
12          cable authority (as defined in section 813(a)(5) of  
13          the Employee Retirement Income Security Act of  
14          1974 (as amended by this Act)) by the arrangement  
15          of an application for certification of the arrangement  
16          under part 8 of subtitle B of title I of such Act—

17                (A) such arrangement shall be deemed to  
18                be a group health plan for purposes of title I  
19                of such Act,

20                (B) the requirements of sections 801(a)(1)  
21                and 803(a)(1) of the Employee Retirement In-  
22                come Security Act of 1974 shall be deemed met  
23                with respect to such arrangement,

24                (C) the requirements of section 803(b) of  
25                such Act shall be deemed met, if the arrange-

1           ment is operated by a board of directors  
2           which—

3                   (i) is elected by the participating em-  
4                   ployers, with each employer having one  
5                   vote, and

6                   (ii) has complete fiscal control over  
7                   the arrangement and which is responsible  
8                   for all operations of the arrangement,

9           (D) the requirements of section 804(a) of  
10          such Act shall be deemed met with respect to  
11          such arrangement,

12          (E) the arrangement may be certified by  
13          any applicable authority with respect to its op-  
14          erations in any State only if it operates in such  
15          State on the date of certification.

16          The provisions of this subsection shall cease to apply  
17          with respect to any such arrangement at such time  
18          after the date of the enactment of this Act as the  
19          applicable requirements of this subsection are not  
20          met with respect to such arrangement.

21          (2) DEFINITIONS.—For purposes of this sub-  
22          section, the terms “group health plan,” “medical  
23          care,” and “participating employer” shall have the  
24          meanings provided in section 813 of the Employee  
25          Retirement Income Security Act of 1974, except

1       that the reference in paragraph (7) of such section  
2       to an “association health plan” shall be deemed a  
3       reference to an arrangement referred to in this sub-  
4       section.

5       (d) PILOT PROGRAM FOR SELF-INSURED ASSOCIA-  
6       TION HEALTH PLANS.—

7           (1) IN GENERAL.—During the pilot program  
8       period, association health plans which offer benefit  
9       options which do not consist of health insurance cov-  
10      erage may be certified under part 8 of subtitle B of  
11      title I of the Employee Retirement Income Security  
12      Act of 1974 only if such plans consist of the follow-  
13      ing:

14           (A) plans which offered such coverage on  
15      the date of the enactment of this Act,

16           (B) plans under which the sponsor does  
17      not restrict membership to one or more trades  
18      and businesses or industries and whose eligible  
19      participating employers represent a broad cross-  
20      section of trades and businesses or industries,  
21      or

22           (C) plans whose eligible participating em-  
23      ployers represent one or more trades or busi-  
24      nesses, or one or more industries, which have  
25      been indicated as having average or above-aver-

1 age health insurance risk or health claims expe-  
2 rience by reason of State rate filings, denials of  
3 coverage, proposed premium rate levels, and  
4 other means demonstrated by such plans in ac-  
5 cordance with regulations which the Secretary  
6 shall prescribe, including (but not limited to)  
7 the following: agriculture; automobile dealer-  
8 ships; barbering and cosmetology; child care;  
9 construction; dance, theatrical, and orchestra  
10 productions; disinfecting and pest control; eat-  
11 ing and drinking establishments; fishing; hos-  
12 pitals; labor organizations; logging; manufactur-  
13 ing (metals); mining; medical and dental prac-  
14 tices; medical laboratories; sanitary services;  
15 transportation (local and freight); and  
16 warehousing.

17 (2) PILOT PROGRAM PERIOD.—For purposes of  
18 this subsection, the term “pilot program period”  
19 means the 5-year period beginning on January 1,  
20 1999.

1       **TITLE II—AMENDMENTS TO**  
2       **PUBLIC HEALTH SERVICE ACT**  
3       **Subtitle   A—Patient    Protections**  
4       **and Point of Service Coverage**  
5       **Requirements**

6       **SEC. 2001. PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
7                   **ADVICE, EMERGENCY MEDICAL CARE, OB-**  
8                   **STETRIC AND GYNECOLOGICAL CARE, PEDI-**  
9                   **ATRIC CARE.**

10       (a) IN GENERAL.—Subpart 2 of part A of title  
11 XXVII of the Public Health Service Act is amended by  
12 adding at the end the following new section:

13       **“SEC. 2706. PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
14                   **ADVICE, EMERGENCY MEDICAL CARE, OB-**  
15                   **STETRIC AND GYNECOLOGICAL CARE, PEDI-**  
16                   **ATRIC CARE.**

17       “(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL  
18 ADVICE.—

19               “(1) IN GENERAL.—In the case of any health  
20 care professional acting within the lawful scope of  
21 practice in the course of carrying out a contractual  
22 employment arrangement or other direct contractual  
23 arrangement between such professional and a group  
24 health plan or a health insurance issuer offering  
25 health insurance coverage in connection with a group

1 health plan, the plan or issuer with which such con-  
2 tractual employment arrangement or other direct  
3 contractual arrangement is maintained by the pro-  
4 fessional may not impose on such professional under  
5 such arrangement any prohibition with respect to  
6 advice, provided to a participant or beneficiary  
7 under the plan who is a patient, about the health  
8 status of the participant or beneficiary or the medi-  
9 cal care or treatment for the condition or disease of  
10 the participant or beneficiary, regardless of whether  
11 benefits for such care or treatment are provided  
12 under the plan or health insurance coverage offered  
13 in connection with the plan.

14 “(2) HEALTH CARE PROFESSIONAL DEFINED.—  
15 For purposes of this subsection, the term ‘health  
16 care professional’ means a physician (as defined in  
17 section 1861(r) of the Social Security Act) or other  
18 health care professional if coverage for the profes-  
19 sional’s services is provided under the group health  
20 plan for the services of the professional. Such term  
21 includes a podiatrist, optometrist, chiropractor, psy-  
22 chologist, dentist, physician assistant, physical or oc-  
23 cupational therapist and therapy assistant, speech-  
24 language pathologist, audiologist, registered or li-  
25 censed practical nurse (including nurse practitioner,

1 clinical nurse specialist, certified registered nurse  
2 anesthetist, and certified nurse—midwife), licensed  
3 certified social worker, registered respiratory thera-  
4 pist, and certified respiratory therapy technician.

5 “(b) PATIENT ACCESS TO EMERGENCY MEDICAL  
6 CARE.—

7 “(1) IN GENERAL.—To the extent that the  
8 group health plan (or health insurance issuer offer-  
9 ing health insurance coverage in connection with the  
10 plan) provides for any benefits consisting of emer-  
11 gency medical care (as defined in section  
12 503(b)(9)(I) of the Employee Retirement Income Se-  
13 curity Act of 1974), except for items or services spe-  
14 cifically excluded—

15 “(A) the plan or issuer shall provide bene-  
16 fits, without requiring preauthorization, for ap-  
17 propriate emergency medical screening exami-  
18 nations (within the capability of the emergency  
19 facility, including ancillary services routinely  
20 available to the emergency facility) to the extent  
21 that a prudent layperson, who possesses an av-  
22 erage knowledge of health and medicine, would  
23 determine such examinations to be necessary in  
24 order to determine whether emergency medical  
25 care (as so defined) is required, and

1           “(B) the plan or issuer shall provide bene-  
2           fits for additional emergency medical services  
3           following an emergency medical screening exam-  
4           ination (if determined necessary under subpara-  
5           graph (A)) to the extent that a prudent emer-  
6           gency medical professional would determine  
7           such additional emergency services to be nec-  
8           essary to avoid the consequences described in  
9           section 503(b)(9)(I) of such Act.

10          “(2) UNIFORM COST-SHARING REQUIRED.—

11       Nothing in this subsection shall be construed as pre-  
12       venting a group health plan or issuer from imposing  
13       any form of cost-sharing applicable to any partici-  
14       pant or beneficiary (including coinsurance, copay-  
15       ments, deductibles, and any other charges) in rela-  
16       tion to benefits described in paragraph (1), if such  
17       form of cost-sharing is uniformly applied under such  
18       plan, with respect to similarly situated participants  
19       and beneficiaries, to all benefits consisting of emer-  
20       gency medical care (as defined in section  
21       503(b)(9)(I) of the Employee Retirement Income Se-  
22       curity Act of 1974) provided to such similarly situ-  
23       ated participants and beneficiaries under the plan.

24          “(c) PATIENT ACCESS TO OBSTETRIC AND GYNECO-  
25       LOGICAL CARE.



1           “(1) IN GENERAL.—In any case in which a  
2           group health plan (or a health insurance issuer of-  
3           fering health insurance coverage in connection with  
4           the plan)—

5                   “(A) provides benefits under the terms of  
6           the plan consisting of—

7                           “(i) routine gynecological care (such  
8                           as preventive women’s health examina-  
9                           tions), or

10                           “(ii) routine obstetric care (such as  
11                           routine pregnancy-related services),  
12           provided by a participating physician who spe-  
13           cializes in such care (or provides benefits con-  
14           sisting of payment for such care), and

15                   “(B) the plan requires or provides for des-  
16           ignation by a participant or beneficiary of a  
17           participating primary care provider,

18           if the primary care provider designated by such a  
19           participant or beneficiary is not such a physician,  
20           then the plan (or issuer) shall meet the requirements  
21           of paragraph (2).

22           “(2) REQUIREMENTS.—A group health plan (or  
23           a health insurance issuer offering health insurance  
24           coverage in connection with the plan) meets the re-  
25           quirements of this paragraph, in connection with

1       benefits described in paragraph (1) consisting of  
2       care described in clause (i) or (ii) of paragraph  
3       (1)(A) (or consisting of payment therefor), if the  
4       plan (or issuer)—

5               “(A) does not require authorization or a  
6       referral by the primary care provider in order  
7       to obtain such benefits, and

8               “(B) treats the ordering of other routine  
9       care of the same type, by the participating phy-  
10      sician providing the care described in clause (i)  
11      or (ii) of paragraph (1)(A), as the authorization  
12      of the primary care provider with respect to  
13      such care.

14              “(3) CONSTRUCTION.—Nothing in paragraph  
15      (2)(B) shall waive any requirements of coverage re-  
16      lating to medical necessity or appropriateness with  
17      respect to coverage of gynecological or obstetric care  
18      so ordered.

19              “(d) PATIENT ACCESS TO PEDIATRIC CARE.—

20              “(1) IN GENERAL.—In any case in which a  
21      group health plan (or a health insurance issuer of-  
22      fering health insurance coverage in connection with  
23      the plan) provides benefits consisting of routine pe-  
24      diatric care provided by a participating physician  
25      who specializes in pediatrics (or consisting of pay-

1       ment for such care) and the plan requires or pro-  
 2       vides for designation by a participant or beneficiary  
 3       of a participating primary care provider, the plan (or  
 4       issuer) shall provide that such a participating physi-  
 5       cian may be designated, if available, by a parent or  
 6       guardian of any beneficiary under the plan is who  
 7       under 18 years of age, as the primary care provider  
 8       with respect to any such benefits.

9               “(2) CONSTRUCTION.—Nothing in paragraph  
 10       (1) shall waive any requirements of coverage relating  
 11       to medical necessity or appropriateness with respect  
 12       to coverage of pediatric care.

13       “(e) TREATMENT OF MULTIPLE COVERAGE OP-  
 14       TIONS.—In the case of a plan providing benefits under two  
 15       or more coverage options, the requirements of subsections  
 16       (c) and (d) shall apply separately with respect to each cov-  
 17       erage option.”.

18       (c) EFFECTIVE DATE AND RELATED RULES.—

19               (1) IN GENERAL.—The amendments made by  
 20       this section shall apply with respect to plan years be-  
 21       ginning on or after January 1 of the second cal-  
 22       endar year following the date of the enactment of  
 23       this Act, except that the Secretary of Health and  
 24       Human Services may issue regulations before such  
 25       date under such amendments. The Secretary shall

1 first issue all regulations necessary to carry out the  
2 amendments made by this section before the effective date thereof.

4 (2) LIMITATION ON ENFORCEMENT ACTIONS.—

5 No enforcement action shall be taken, pursuant to  
6 the amendments made by this section, against a  
7 group health plan or health insurance issuer with respect to a violation of a requirement imposed by  
8 such amendments before the date of issuance of regulations issued in connection with such requirement,  
9 if the plan or issuer has sought to comply in good  
10 faith with such requirement.

13 (3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health  
14 plan maintained pursuant to one or more collective  
15 bargaining agreements between employee representatives and one or more employers ratified before the  
16 date of the enactment of this Act, the amendments  
17 made by this section shall not apply with respect to  
18 plan years beginning before the later of—  
19

21 (1) the date on which the last of the collective bargaining agreements relating to the plan  
22 terminates (determined without regard to any  
23 extension thereof agreed to after the date of the  
24 enactment of this Act), or  
25

1 (2) January 1, 2001.

2 For purposes of this paragraph, any plan amend-  
 3 ments made pursuant to a collective bargaining  
 4 agreement relating to the plan which amends the  
 5 plan solely to conform to any requirement added by  
 6 this section shall not be treated as a termination of  
 7 such collective bargaining agreement.

8 **SEC. 2002. REQUIRING HEALTH MAINTENANCE ORGANIZA-**  
 9 **TIONS TO OFFER OPTION OF POINT-OF-SERV-**  
 10 **ICE COVERAGE.**

11 (a) IN GENERAL.—Title XXVII of the Public Health  
 12 Service Act is amended by inserting after section 2713 the  
 13 following new section:

14 **“SEC. 2714. REQUIRING OFFERING OF OPTION OF POINT-**  
 15 **OF-SERVICE COVERAGE.**

16 “(a) REQUIREMENT TO OFFER COVERAGE OPTION  
 17 TO CERTAIN EMPLOYERS.—Except as provided in sub-  
 18 section (c), any health insurance issuer which—

19 “(1) is a health maintenance organization (as  
 20 defined in section 2791(b)(3)), and

21 “(2) which provides for coverage of services of  
 22 one or more classes of health care professionals  
 23 under health insurance coverage offered in connec-  
 24 tion with a group health plan only if such services  
 25 are furnished exclusively through health care profes-

1        sionals within such class or classes who are members  
2        of a closed panel of health care professionals,  
3 the issuer shall make available to the plan sponsor in con-  
4 nection with such a plan a coverage option which provides  
5 for coverage of such services which are furnished through  
6 such class (or classes) of health care professionals regard-  
7 less of whether or not the professionals are members of  
8 such panel.

9        “(b) REQUIREMENT TO OFFER SUPPLEMENTAL COV-  
10 ERAGE TO PARTICIPANTS IN CERTAIN CASES.—Except as  
11 provided in subsection (c), if a health insurance issuer  
12 makes available a coverage option under and described in  
13 subsection (a) to a plan sponsor of a group health plan  
14 and the sponsor declines to contract for such coverage op-  
15 tion, then the issuer shall make available in the individual  
16 insurance market to each participant in the group health  
17 plan optional separate supplemental health insurance cov-  
18 erage in the individual health insurance market which con-  
19 sists of services identical to those provided under such cov-  
20 erage provided through the closed panel under the group  
21 health plan but are furnished exclusively by health care  
22 professionals who are not members of such a closed panel.

23        “(c) EXCEPTIONS.—

24                “(1) OFFERING OF NON-PANEL OPTION.—Sub-  
25        sections (a) and (b) shall not apply with respect to

1 a group health plan if the plan offers a coverage op-  
2 tion that provides coverage for services that may be  
3 furnished by a class or classes of health care profes-  
4 sionals who are not in a closed panel. This para-  
5 graph shall be applied separately to distinguishable  
6 groups of employees under the plan.

7 “(2) AVAILABILITY OF COVERAGE THROUGH  
8 HEALTHMART.—Subsections (a) and (b) shall not  
9 apply to a group health plan if the health insurance  
10 coverage under the plan is made available through a  
11 HealthMart (as defined in section 2801) and if any  
12 health insurance coverage made available through  
13 the HealthMart provides for coverage of the services  
14 of any class of health care professionals other than  
15 through a closed panel of professionals.

16 “(3) RELICENSURE EXEMPTION.—Subsections  
17 (a) and (b) shall not apply to a health maintenance  
18 organization in a State in any case in which—

19 “(A) the organization demonstrates to the  
20 applicable authority that the organization has  
21 made a good faith effort to obtain (but has  
22 failed to obtain) a contract between the organi-  
23 zation and any other health insurance issuer  
24 providing for the coverage option or supple-  
25 mental coverage described in subsection (a) or

1 (b), as the case may be, within the applicable  
2 service area of the organization, and

3 “(B) the State requires the organization to  
4 receive or qualify for a separate license, as an  
5 indemnity insurer or otherwise, in order to offer  
6 such coverage option or supplemental coverage,  
7 respectively.

8 The applicable authority may require that the orga-  
9 nization demonstrate that it meets the requirements  
10 of the previous sentence no more frequently than  
11 once every two years.

12 “(4) INCREASED COSTS.—Subsections (a) and  
13 (b) shall not apply to a health maintenance organi-  
14 zation if the organization demonstrates to the appli-  
15 cable authority, in accordance with generally accept-  
16 ed actuarial practice, that, on either a prospective or  
17 retroactive basis, the premium for the coverage op-  
18 tion or supplemental coverage required to be made  
19 available under such respective subsection exceeds by  
20 more than 1 percent the premium for the coverage  
21 consisting of services which are furnished through a  
22 closed panel of health care professionals in the class  
23 or classes involved. The applicable authority may re-  
24 quire that the organization demonstrate such an in-  
25 crease no more frequently than once every two years.



1 This paragraph shall be applied on an average per  
2 enrollee or similar basis.

3 “(5) COLLECTIVE BARGAINING AGREEMENTS.—  
4 Subsections (a) and (b) shall not apply in connection  
5 with a group health plan if the plan is established  
6 or maintained pursuant to one or more collective  
7 bargaining agreements.

8 “(d) DEFINITIONS.—For purposes of this section:

9 “(1) COVERAGE THROUGH CLOSED PANEL.—  
10 Health insurance coverage for a class of health care  
11 professionals shall be treated as provided through a  
12 closed panel of such professionals only if such cov-  
13 erage consists of coverage of items or services con-  
14 sisting of professionals services which are reim-  
15 bursed for or provided only within a limited network  
16 of such professionals.

17 “(2) HEALTH CARE PROFESSIONAL.—The term  
18 ‘health care professional’ has the meaning given  
19 such term in section 2706(a)(2).”.

20 (b) EFFECTIVE DATE.—The amendment made by  
21 subsection (a) shall apply to coverage offered on or after  
22 January 1 of the second calendar year following the date  
23 of the enactment of this Act.

1           **Subtitle B—Patient Access to**  
2                           **Information**

3   **SEC. 2101. PATIENT ACCESS TO INFORMATION REGARDING**  
4                   **PLAN COVERAGE, MANAGED CARE PROCE-**  
5                   **DURES, HEALTH CARE PROVIDERS, AND**  
6                   **QUALITY OF MEDICAL CARE.**

7           (a) IN GENERAL.—Subpart 2 of part A of title  
8 XXVII of the Public Health Service Act (as amended by  
9 subtitle A of this title) is amended further by adding at  
10 the end the following new section:

11   **“SEC. 2707. PATIENT ACCESS TO INFORMATION REGARD-**  
12                   **ING PLAN COVERAGE, MANAGED CARE PRO-**  
13                   **CEDURES, HEALTH CARE PROVIDERS, AND**  
14                   **QUALITY OF MEDICAL CARE.**

15           “(a) DISCLOSURE REQUIREMENT.—Each health in-  
16 surance issuer offering health insurance coverage in con-  
17 nection with a group health plan shall provide the adminis-  
18 trator of such plan on a timely basis with the information  
19 necessary to enable the administrator to include in the  
20 summary plan description of the plan required under sec-  
21 tion 102 of the Employee Retirement Income Security Act  
22 of 1974 (or each summary plan description in any case  
23 in which different summary plan descriptions are appro-  
24 priate under part 1 of subtitle B of title I of such Act  
25 for different options of coverage) the information required

1 under subsections (b), (c), (d), and (e)(2)(A). To the ex-  
 2 tent that any such issuer provides such information on a  
 3 timely basis to plan participants and beneficiaries, the re-  
 4 quirements of this subsection shall be deemed satisfied in  
 5 the case of such plan with respect to such information.

6 “(b) PLAN BENEFITS.—The information required  
 7 under subsection (a) includes the following:

8 “(1) COVERED ITEMS AND SERVICES.—

9 “(A) CATEGORIZATION OF INCLUDED BEN-  
 10 EFITS.—A description of covered benefits, cat-  
 11 egorized by—

12 “(i) types of items and services (in-  
 13 cluding any special disease management  
 14 program), and

15 “(ii) types of health care professionals  
 16 providing such items and services.

17 “(B) EMERGENCY MEDICAL CARE.—A de-  
 18 scription of the extent to which the coverage in-  
 19 cludes emergency medical care (including the  
 20 extent to which the coverage provides for access  
 21 to urgent care centers), and any definitions pro-  
 22 vided under in connection with such coverage  
 23 for the relevant coverage terminology referring  
 24 to such care.

1           “(C) PREVENTATIVE SERVICES.—A de-  
2           scription of the extent to which the coverage in-  
3           cludes benefits for preventative services.

4           “(D) DRUG FORMULARIES.—A description  
5           of the extent to which covered benefits are de-  
6           termined by the use or application of a drug  
7           formulary and a summary of the process for de-  
8           termining what is included in such formulary.

9           “(E) COBRA CONTINUATION COV-  
10          ERAGE.—A description of the benefits available  
11          under the coverage provided pursuant to part 6  
12          of subtitle B of title I of the Employee Retire-  
13          ment Income Security Act of 1974.

14          “(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-  
15          TIONS ON COVERED BENEFITS.—

16               “(A) CATEGORIZATION OF EXCLUDED  
17               BENEFITS.—A description of benefits specifi-  
18               cally excluded from coverage, categorized by  
19               types of items and services.

20               “(B) UTILIZATION REVIEW AND  
21               PREAUTHORIZATION REQUIREMENTS.—Whether  
22               coverage for medical care is limited or excluded  
23               on the basis of utilization review or  
24               preauthorization requirements.

1           “(C) LIFETIME, ANNUAL, OR OTHER PE-  
2           RIOD LIMITATIONS.—A description of the cir-  
3           cumstances under which, and the extent to  
4           which, coverage is subject to lifetime, annual, or  
5           other period limitations, categorized by types of  
6           benefits.

7           “(D) CUSTODIAL CARE.—A description of  
8           the circumstances under which, and the extent  
9           to which, the coverage of benefits for custodial  
10          care is limited or excluded, and a statement of  
11          the definition used in connection with such cov-  
12          erage for custodial care.

13          “(E) EXPERIMENTAL TREATMENTS.—  
14          Whether coverage for any medical care is lim-  
15          ited or excluded because it constitutes experi-  
16          mental treatment or technology, and any defini-  
17          tions provided in connection with such coverage  
18          for the relevant plan terminology referring to  
19          such limited or excluded care.

20          “(F) MEDICAL APPROPRIATENESS OR NE-  
21          CESSITY.—Whether coverage for medical care  
22          may be limited or excluded by reason of a fail-  
23          ure to meet the plan’s requirements for medical  
24          appropriateness or necessity, and any defini-  
25          tions provided in connection with such coverage

1 for the relevant coverage terminology referring  
2 to such limited or excluded care.

3 “(G) SECOND OR SUBSEQUENT OPIN-  
4 IONS.—A description of the circumstances  
5 under which, and the extent to which, coverage  
6 for second or subsequent opinions is limited or  
7 excluded.

8 “(H) SPECIALTY CARE.—A description of  
9 the circumstances under which, and the extent  
10 to which, coverage of benefits for specialty care  
11 is conditioned on referral from a primary care  
12 provider.

13 “(I) CONTINUITY OF CARE.—A description  
14 of the circumstances under which, and the ex-  
15 tent to which, coverage of items and services  
16 provided by any health care professional is lim-  
17 ited or excluded by reason of the departure by  
18 the professional from any defined set of provid-  
19 ers.

20 “(J) RESTRICTIONS ON COVERAGE OF  
21 EMERGENCY SERVICES.—A description of the  
22 circumstances under which, and the extent to  
23 which, the coverage, in including emergency  
24 medical care furnished to a participant or bene-  
25 ficiary of the plan imposes any financial respon-

1           sibility described in subsection (c) on partici-  
2           pants or beneficiaries or limits or conditions  
3           benefits for such care subject to any other term  
4           or condition of such coverage.

5           “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-  
6 ITIES.—The information required under subsection (a) in-  
7 cludes an explanation of—

8           “(1) a participant’s financial responsibility for  
9           payment of premiums, coinsurance, copayments,  
10          deductibles, and any other charges, and

11          “(2) the circumstances under which, and the  
12          extent to which, the participant’s financial respon-  
13          sibility described in paragraph (1) may vary, includ-  
14          ing any distinctions based on whether a health care  
15          provider from whom covered benefits are obtained is  
16          included in a defined set of providers.

17          “(d) DISPUTE RESOLUTION PROCEDURES.—The in-  
18 formation required under subsection (a) includes a de-  
19 scription of the processes adopted in connection with such  
20 coverage pursuant to section 503(b) of the Employee Re-  
21 tirement Income Security Act of 1974, including—

22          “(1) descriptions thereof relating specifically  
23          to—

24                  “(A) coverage decisions,

1                   “(B) internal review of coverage decisions,  
2                   and

3                   “(C) any external review of coverage deci-  
4                   sions, and

5                   “(2) the procedures and time frames applicable  
6                   to each step of the processes referred to in subpara-  
7                   graphs (A), (B), and (C) of paragraph (1).

8                   “(e) INFORMATION AVAILABLE ON REQUEST.—

9                   “(1) ACCESS TO PLAN BENEFIT INFORMATION  
10                  IN ELECTRONIC FORM.—

11                  “(A) IN GENERAL.—A group health plan  
12                  (and a health insurance issuer offering health  
13                  insurance coverage in connection with a group  
14                  health plan) shall, upon written request (made  
15                  not more frequently than annually), make avail-  
16                  able to participants and beneficiaries, in a gen-  
17                  erally recognized electronic format, the follow-  
18                  ing information:

19                         “(i) the latest summary plan descrip-  
20                         tion, including the latest summary of ma-  
21                         terial modifications, and

22                         “(ii) the actual plan provisions setting  
23                         forth the benefits available under the plan,  
24                         to the extent such information relates to the  
25                         coverage options under the plan available to the



1 participant or beneficiary. A reasonable charge  
2 may be made to cover the cost of providing  
3 such information in such generally recognized  
4 electronic format. The Secretary may by regula-  
5 tion prescribe a maximum amount which will  
6 constitute a reasonable charge under the pre-  
7 ceding sentence.

8 “(B) ALTERNATIVE ACCESS.—The require-  
9 ments of this paragraph may be met by making  
10 such information generally available (rather  
11 than upon request) on the Internet or on a pro-  
12 prietary computer network in a format which is  
13 readily accessible to participants and bene-  
14 ficiaries.

15 “(2) ADDITIONAL INFORMATION TO BE PRO-  
16 VIDED ON REQUEST.—

17 “(A) INCLUSION IN SUMMARY PLAN DE-  
18SCRIPTION OF SUMMARY OF ADDITIONAL IN-  
19FORMATION.—The information required under  
20 subsection (a) includes a summary description  
21 of the types of information required by this  
22 subsection to be made available to participants  
23 and beneficiaries on request.

24 “(B) INFORMATION REQUIRED FROM  
25 PLANS AND ISSUERS ON REQUEST.—In addition

1 to information required to be included in sum-  
2 mary plan descriptions under this subsection, a  
3 group health plan (and a health insurance  
4 issuer offering health insurance coverage in  
5 connection with a group health plan) shall pro-  
6 vide the following information to a participant  
7 or beneficiary on request:

8 “(i) NETWORK CHARACTERISTICS.—If  
9 the plan (or issuer) utilizes a defined set of  
10 providers under contract with the plan (or  
11 issuer), a detailed list of the names of such  
12 providers and their geographic location, set  
13 forth separately with respect to primary  
14 care providers and with respect to special-  
15 ists.

16 “(ii) CARE MANAGEMENT INFORMA-  
17 TION.—A description of the circumstances  
18 under which, and the extent to which, the  
19 plan has special disease management pro-  
20 grams or programs for persons with dis-  
21 abilities, indicating whether these pro-  
22 grams are voluntary or mandatory and  
23 whether a significant benefit differential  
24 results from participation in such pro-  
25 grams.

1           “(iii) INCLUSION OF DRUGS AND  
2 BIOLOGICALS IN FORMULARIES.—A state-  
3 ment of whether a specific drug or biologi-  
4 cal is included in a formulary used to de-  
5 termine benefits under the plan and a de-  
6 scription of the procedures for considering  
7 requests for any patient-specific waivers.

8           “(iv) PROCEDURES FOR DETERMINING  
9 EXCLUSIONS BASED ON MEDICAL NECES-  
10 SITY OR EXPERIMENTAL TREATMENTS.—  
11 Upon receipt by the participant or bene-  
12 ficiary of any notification of an adverse  
13 coverage decision based on a determination  
14 relating to medical necessity or an experi-  
15 mental treatment or technology, a descrip-  
16 tion of the procedures and medically-based  
17 criteria used in such decision.

18           “(v) PREAUTHORIZATION AND UTILI-  
19 ZATION REVIEW PROCEDURES.—Upon re-  
20 ceipt by the participant or beneficiary of  
21 any notification of an adverse coverage de-  
22 cision, a description of the basis on which  
23 any preauthorization requirement or any  
24 utilization review requirement has resulted  
25 in such decision.

1           “(vi) ACCREDITATION STATUS OF  
2 HEALTH INSURANCE ISSUERS AND SERV-  
3 ICE PROVIDERS.—A description of the ac-  
4 creditation and licencing status (if any) of  
5 each health insurance issuer offering  
6 health insurance coverage in connection  
7 with the plan and of any utilization review  
8 organization utilized by the issuer or the  
9 plan, together with the name and address  
10 of the accrediting or licencing authority.

11           “(vii) MEASURES OF ENROLLEE SAT-  
12 ISFACTION.—The latest information (if  
13 any) maintained by the plan, or by any  
14 health insurance issuer offering health in-  
15 surance coverage in connection with the  
16 plan, relating to enrollee satisfaction.

17           “(viii) QUALITY PERFORMANCE MEAS-  
18 URES.—The latest information (if any)  
19 maintained by the plan, or by any health  
20 insurance issuer offering health insurance  
21 coverage in connection with the plan, relat-  
22 ing to quality of performance of the deliv-  
23 ery of medical care with respect to cov-  
24 erage options offered under the plan and

1 of health care professionals and facilities  
2 providing medical care under the plan.

3 “(C) INFORMATION REQUIRED FROM  
4 HEALTH CARE PROFESSIONALS ON REQUEST.—  
5 Any health care professional treating a partici-  
6 pant or beneficiary under a group health plan  
7 shall provide to the participant or beneficiary,  
8 on request, a description of his or her profes-  
9 sional qualifications (including board certifi-  
10 cation status, licensing status, and accreditation  
11 status, if any), privileges, and experience and a  
12 general description by category (including sal-  
13 ary, fee-for-service, capitation, and such other  
14 categories as may be specified in regulations of  
15 the Secretary) of the applicable method by  
16 which such professional is compensated in con-  
17 nection with the provision of such medical care.

18 “(D) INFORMATION REQUIRED FROM  
19 HEALTH CARE FACILITIES ON REQUEST.—Any  
20 health care facility from which a participant or  
21 beneficiary has sought treatment under a group  
22 health plan shall provide to the participant or  
23 beneficiary, on request, a description of the fa-  
24 cility’s corporate form or other organizational  
25 form and all forms of licensing and accredita-

1           tion status (if any) assigned to the facility by  
2           standard-setting organizations.

3           “(f) ACCESS TO INFORMATION RELEVANT TO THE  
4 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR  
5 BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to  
6 information otherwise required to be made available under  
7 this section, a group health plan (and a health insurance  
8 issuer offering health insurance coverage in connection  
9 with a group health plan) shall, upon written request  
10 (made not more frequently than annually), make available  
11 to a participant in connection with a period of enrollment  
12 the summary plan description for any coverage option  
13 under the plan under which the participant is eligible to  
14 enroll and any information described in clauses (i), (ii),  
15 (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

16           “(g) ADVANCE NOTICE OF CHANGES IN DRUG  
17 FORMULARIES.—Not later than 30 days before the effec-  
18 tive of date of any exclusion of a specific drug or biological  
19 from any drug formulary under the plan that is used in  
20 the treatment of a chronic illness or disease, the plan shall  
21 take such actions as are necessary to reasonably ensure  
22 that plan participants are informed of such exclusion. The  
23 requirements of this subsection may be satisfied—

1 “(1) by inclusion of information in publications  
 2 broadly distributed by plan sponsors, employers, or  
 3 employee organizations,

4 “(2) by electronic means of communication (in-  
 5 cluding the Internet or proprietary computer net-  
 6 works in a format which is readily accessible to par-  
 7 ticipants),

8 “(3) by timely informing participants who,  
 9 under an ongoing program maintained under the  
 10 plan, have submitted their names for such notifica-  
 11 tion, or

12 “(4) by any other reasonable means of timely  
 13 informing plan participants.”.

14 **SEC. 2102. REPORTING ON FRAUD AND ABUSE ENFORCE-**  
 15 **MENT ACTIVITIES.**

16 The General Accounting Office shall—

17 (1) monitor—

18 (A) the compliance of the Department of  
 19 Justice and all United States Attorneys—with  
 20 the guideline entitled “Guidance on the Use of  
 21 the False Claims Act in Civil Health Care Mat-  
 22 ters” issued by the Department on June 3,  
 23 1998, including any revisions to such guideline,  
 24 and

1 (B) the compliance of the Office of the In-  
2 spector General of the Department of Health  
3 and Human Services with the protocols and  
4 guidelines entitled “National Project Proto-  
5 cols—Best Practice Guidelines” issued by the  
6 Inspector General on June 3, 1998, including  
7 any revisions to such protocols and guidelines,  
8 and

9 (2) submit a report on such compliance to the  
10 Committee on Commerce of the House of Represent-  
11 atives not later than February 1, 1999, and every  
12 year thereafter for a period of four years ending  
13 February 1, 2002.

14 **SEC. 2103. EFFECTIVE DATE.**

15 (a) IN GENERAL.—The amendments made by this  
16 subtitle shall apply with respect to plan years beginning  
17 on or after January 1 of the second calendar year follow-  
18 ing the date of the enactment of this Act. The Secretary  
19 shall first issue all regulations necessary to carry out the  
20 amendments made by this subtitle before such date.

21 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
22 enforcement action shall be taken, pursuant to the amend-  
23 ments made by this subtitle, against a group health plan  
24 or health insurance issuer with respect to a violation of  
25 a requirement imposed by such amendments before the



1 date of issuance of final regulations issued in connection  
 2 with such requirement, if the plan or issuer has sought  
 3 to comply in good faith with such requirement.

## 4 **Subtitle C—HealthMarts**

### 5 **SEC. 2201. SHORT TITLE OF SUBTITLE.**

6 This subtitle may be cited as the “Health Care Con-  
 7 sumer Empowerment Act of 1998”.

### 8 **SEC. 2202. EXPANSION OF CONSUMER CHOICE THROUGH** 9 **HEALTHMARTS.**

10 The Public Health Service Act is amended by adding  
 11 at the end the following new title:

#### 12 “TITLE XXVIII—HEALTHMARTS

##### 13 **“SEC. 2801. DEFINITION OF HEALTHMART.**

14 “(a) IN GENERAL.—For purposes of this title, the  
 15 term ‘HealthMart’ means a legal entity that meets the fol-  
 16 lowing requirements:

17 “(1) ORGANIZATION.—The HealthMart is a  
 18 nonprofit organization operated under the direction  
 19 of a board of directors which is composed of rep-  
 20 resentatives of not fewer than 2 and in equal num-  
 21 bers from each of the following:

22 “(A) Small employers.

23 “(B) Employees of small employers.

24 “(C) Health care providers, which may be  
 25 physicians, other health care professionals,

1 health care facilities, or any combination there-  
2 of.

3 “(D) Entities, such as insurance compa-  
4 nies, health maintenance organizations, and li-  
5 censed provider-sponsored organizations, that  
6 underwrite or administer health benefits cov-  
7 erage.

8 “(2) OFFERING HEALTH BENEFITS COV-  
9 ERAGE.—

10 “(A) IN GENERAL.—The HealthMart, in  
11 conjunction with those health insurance issuers  
12 that offer health benefits coverage through the  
13 HealthMart, makes available health benefits  
14 coverage in the manner described in subsection  
15 (b) to all small employers and eligible employees  
16 in the manner described in subsection (c)(2) at  
17 rates (including employer’s and employee’s  
18 share) that are established by the health insur-  
19 ance issuer on a policy or product specific basis  
20 and that may vary only as permissible under  
21 State law. A HealthMart is deemed to be a  
22 group health plan for purposes of applying sec-  
23 tion 702 of the Employee Retirement Income  
24 Security Act of 1974, section 2702 of this Act,  
25 and section 9802(b) of the Internal Revenue

1 Code of 1986 (which limit variation among  
2 similarly situated individuals of required pre-  
3 miums for health benefits coverage on the basis  
4 of health status-related factors).

5 “(B) NONDISCRIMINATION IN COVERAGE  
6 OFFERED.—

7 “(i) IN GENERAL.—Subject to clause  
8 (ii), the HealthMart may not offer health  
9 benefits coverage to an eligible employee in  
10 a geographic area (as specified under para-  
11 graph (3)(A)) unless the same coverage is  
12 offered to all such employees in the same  
13 geographic area. Section 2711(a)(1)(B) of  
14 this Act limits denial of enrollment of cer-  
15 tain eligible individuals under health bene-  
16 fits coverage in the small group market.

17 “(ii) CONSTRUCTION.—Nothing in  
18 this title shall be construed as requiring or  
19 permitting a health insurance issuer to  
20 provide coverage outside the service area of  
21 the issuer, as approved under State law.

22 “(C) NO FINANCIAL UNDERWRITING.—The  
23 HealthMart provides health benefits coverage  
24 only through contracts with health insurance

1 issuers and does not assume insurance risk with  
2 respect to such coverage.

3 (D) MINIMUM COVERAGE.—By the end of  
4 the first year of its operation and thereafter,  
5 the HealthMart maintains not fewer than 10  
6 purchasers and 100 members.

7 “(3) GEOGRAPHIC AREAS.—

8 “(A) SPECIFICATION OF GEOGRAPHIC  
9 AREAS.—The HealthMart shall specify the geo-  
10 graphic area (or areas) in which it makes avail-  
11 able health benefits coverage offered by health  
12 insurance issuers to small employers. Such an  
13 area shall encompass at least one entire county  
14 or equivalent area.

15 “(B) MULTISTATE AREAS.—In the case of  
16 a HealthMart that serves more than one State,  
17 such geographic areas may be areas that in-  
18 clude portions of two or more contiguous  
19 States.

20 “(C) MULTIPLE HEALTHMARTS PER-  
21 MITTED IN SINGLE GEOGRAPHIC AREA.—Noth-  
22 ing in this title shall be construed as preventing  
23 the establishment and operation of more than  
24 one HealthMart in a geographic area or as lim-

1           iting the number of HealthMarts that may op-  
2           erate in any area.

3           “(4) PROVISION OF ADMINISTRATIVE SERVICES  
4           TO PURCHASERS.—

5                   “(A) IN GENERAL.—The HealthMart pro-  
6           vides administrative services for purchasers.  
7           Such services may include accounting, billing,  
8           enrollment information, and employee coverage  
9           status reports.

10                   “(B) CONSTRUCTION.—Nothing in this  
11           subsection shall be construed as preventing a  
12           HealthMart from serving as an administrative  
13           service organization to any entity.

14           “(5) DISSEMINATION OF INFORMATION.—The  
15           HealthMart collects and disseminates (or arranges  
16           for the collection and dissemination of) consumer-  
17           oriented information on the scope, cost, and enrollee  
18           satisfaction of all coverage options offered through  
19           the HealthMart to its members and eligible individ-  
20           uals. Such information shall be defined by the  
21           HealthMart and shall be in a manner appropriate to  
22           the type of coverage offered. To the extent prac-  
23           ticable, such information shall include information  
24           on provider performance, locations and hours of op-  
25           eration of providers, outcomes, and similar matters.

1 Nothing in this section shall be construed as pre-  
 2 venting the dissemination of such information or  
 3 other information by the HealthMart or by health  
 4 insurance issuers through electronic or other means.

5 “(6) FILING INFORMATION.—The  
 6 HealthMart—

7 “(A) files with the applicable Federal au-  
 8 thority information that demonstrates the  
 9 HealthMart’s compliance with the applicable re-  
 10 quirements of this title; or

11 “(B) in accordance with rules established  
 12 under section 2803(a), files with a State such  
 13 information as the State may require to dem-  
 14 onstrate such compliance.

15 “(b) HEALTH BENEFITS COVERAGE REQUIRE-  
 16 MENTS.—

17 “(1) COMPLIANCE WITH CONSUMER PROTEC-  
 18 TION REQUIREMENTS.—Any health benefits coverage  
 19 offered through a HealthMart shall—

20 “(A) be underwritten by a health insurance  
 21 issuer that—

22 “(i) is licensed (or otherwise regu-  
 23 lated) under State law (or is a community  
 24 health organization that is offering health

1 insurance coverage pursuant to section  
2 330B(a)),

3 “(ii) meets all applicable State stand-  
4 ards relating to consumer protection, sub-  
5 ject to section 2802(b), and

6 “(iii) offers the coverage under a con-  
7 tract with the HealthMart;

8 “(B) subject to paragraph (2), be approved  
9 or otherwise permitted to be offered under  
10 State law; and

11 “(C) provide full portability of creditable  
12 coverage for individuals who remain members of  
13 the same HealthMart notwithstanding that they  
14 change the employer through which they are  
15 members in accordance with the provisions of  
16 the parts 6 and 7 of subtitle B of title I of the  
17 Employee Retirement Income Security Act of  
18 1974 and titles XXII and XXVII of this Act,  
19 so long as both employers are purchasers in the  
20 HealthMart.

21 “(2) ALTERNATIVE PROCESS FOR APPROVAL OF  
22 HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMI-  
23 NATION OR DELAY.—

24 “(A) IN GENERAL.—The requirement of  
25 paragraph (1)(B) shall not apply to a policy or

1 product of health benefits coverage offered in a  
2 State if the health insurance issuer seeking to  
3 offer such policy or product files an application  
4 to waive such requirement with the applicable  
5 Federal authority, and the authority deter-  
6 mines, based on the application and other evi-  
7 dence presented to the authority, that—

8 “(i) either (or both) of the grounds  
9 described in subparagraph (B) for approval  
10 of the application has been met; and

11 “(ii) the coverage meets the applicable  
12 State standards (other than those that  
13 have been preempted under section 2802).

14 “(B) GROUNDS.—The grounds described  
15 in this subparagraph with respect to a policy or  
16 product of health benefits coverage are as fol-  
17 lows:

18 “(i) FAILURE TO ACT ON POLICY,  
19 PRODUCT, OR RATE APPLICATION ON A  
20 TIMELY BASIS.—The State has failed to  
21 complete action on the policy or product  
22 (or rates for the policy or product) within  
23 90 days of the date of the State’s receipt  
24 of a substantially complete application. No  
25 period before the date of the enactment of



1           this section shall be included in determin-  
2           ing such 90-day period.

3           “(ii) DENIAL OF APPLICATION BASED  
4           ON DISCRIMINATORY TREATMENT.—The  
5           State has denied such an application  
6           and—

7                   “(I) the standards or review  
8                   process imposed by the State as a  
9                   condition of approval of the policy or  
10                  product imposes either any material  
11                  requirements, procedures, or stand-  
12                  ards to such policy or product that  
13                  are not generally applicable to other  
14                  policies and products offered or any  
15                  requirements that are preempted  
16                  under section 2802; or

17                  “(II) the State requires the  
18                  issuer, as a condition of approval of  
19                  the policy or product, to offer any pol-  
20                  icy or product other than such policy  
21                  or product.

22           “(C) ENFORCEMENT.—In the case of a  
23           waiver granted under subparagraph (A) to an  
24           issuer with respect to a State, the Secretary  
25           may enter into an agreement with the State

1 under which the State agrees to provide for  
2 monitoring and enforcement activities with re-  
3 spect to compliance of such an issuer and its  
4 health insurance coverage with the applicable  
5 State standards described in subparagraph  
6 (A)(ii). Such monitoring and enforcement shall  
7 be conducted by the State in the same manner  
8 as the State enforces such standards with re-  
9 spect to other health insurance issuers and  
10 plans, without discrimination based on the type  
11 of issuer to which the standards apply. Such an  
12 agreement shall specify or establish mechanisms  
13 by which compliance activities are undertaken,  
14 while not lengthening the time required to re-  
15 view and process applications for waivers under  
16 subparagraph (A).

17 “(3) EXAMPLES OF TYPES OF COVERAGE.—The  
18 health benefits coverage made available through a  
19 HealthMart may include, but is not limited to, any  
20 of the following if it meets the other applicable re-  
21 quirements of this title:

22 “(A) Coverage through a health mainte-  
23 nance organization.

24 “(B) Coverage in connection with a pre-  
25 ferred provider organization.

1           “(C) Coverage in connection with a li-  
2           censed provider-sponsored organization.

3           “(D) Indemnity coverage through an insur-  
4           ance company.

5           “(E) Coverage offered in connection with a  
6           contribution into a medical savings account or  
7           flexible spending account.

8           “(F) Coverage that includes a point-of-  
9           service option.

10          “(G) Coverage offered by a community  
11          health organization (as defined in section  
12          330B(e)).

13          “(H) Any combination of such types of  
14          coverage.

15          “(4) WELLNESS BONUSES FOR HEALTH PRO-  
16          MOTION.—Nothing in this title shall be construed as  
17          precluding a health insurance issuer offering health  
18          benefits coverage through a HealthMart from estab-  
19          lishing premium discounts or rebates for members or  
20          from modifying otherwise applicable copayments or  
21          deductibles in return for adherence to programs of  
22          health promotion and disease prevention so long as  
23          such programs are agreed to in advance by the  
24          HealthMart and comply with all other provisions of

1       this title and do not discriminate among similarly  
2       situated members.

3       “(c) PURCHASERS; MEMBERS; HEALTH INSURANCE  
4 ISSUERS.—

5           “(1) PURCHASERS.—

6               “(A) IN GENERAL.—Subject to the provi-  
7               sions of this title, a HealthMart shall permit  
8               any small employer to contract with the  
9               HealthMart for the purchase of health benefits  
10              coverage for its employees and dependents of  
11              those employees and may not vary conditions of  
12              eligibility (including premium rates and mem-  
13              bership fees) of a small employer to be a pur-  
14              chaser.

15           “(B) ROLE OF ASSOCIATIONS, BROKERS,  
16           AND LICENSED HEALTH INSURANCE AGENTS.—  
17           Nothing in this section shall be construed as  
18           preventing an association, broker, licensed  
19           health insurance agent, or other entity from as-  
20           sisting or representing a HealthMart or small  
21           employers from entering into appropriate ar-  
22           rangements to carry out this title.

23           “(C) PERIOD OF CONTRACT.—The  
24           HealthMart may not require a contract under  
25           subparagraph (A) between a HealthMart and a

1 purchaser to be effective for a period of longer  
2 than 12 months. The previous sentence shall  
3 not be construed as preventing such a contract  
4 from being extended for additional 12-month  
5 periods or preventing the purchaser from volun-  
6 tarily electing a contract period of longer than  
7 12 months.

8 “(D) EXCLUSIVE NATURE OF CON-  
9 TRACT.—Such a contract shall provide that the  
10 purchaser agrees not to obtain or sponsor  
11 health benefits coverage, on behalf of any eligi-  
12 ble employees (and their dependents), other  
13 than through the HealthMart. The previous  
14 sentence shall not apply to an eligible individual  
15 who resides in an area for which no coverage is  
16 offered by any health insurance issuer through  
17 the HealthMart.

18 “(2) MEMBERS.—

19 “(A) IN GENERAL.—Under rules estab-  
20 lished to carry out this title, with respect to a  
21 small employer that has a purchaser contract  
22 with a HealthMart, individuals who are employ-  
23 ees of the employer may enroll for health bene-  
24 fits coverage (including coverage for dependents

1 of such enrolling employees) offered by a health  
2 insurance issuer through the HealthMart.

3 “(B) NONDISCRIMINATION IN ENROLL-  
4 MENT.—A HealthMart may not deny enroll-  
5 ment as a member to an individual who is an  
6 employee (or dependent of such an employee)  
7 eligible to be so enrolled based on health status-  
8 related factors, except as may be permitted con-  
9 sistent with section 2742(b).

10 “(C) ANNUAL OPEN ENROLLMENT PE-  
11 RIOD.—In the case of members enrolled in  
12 health benefits coverage offered by a health in-  
13 surance issuer through a HealthMart, subject  
14 to subparagraph (D), the HealthMart shall pro-  
15 vide for an annual open enrollment period of 30  
16 days during which such members may change  
17 the coverage option in which the members are  
18 enrolled.

19 “(D) RULES OF ELIGIBILITY.—Nothing in  
20 this paragraph shall preclude a HealthMart  
21 from establishing rules of employee eligibility  
22 for enrollment and reenrollment of members  
23 during the annual open enrollment period under  
24 subparagraph (C). Such rules shall be applied  
25 consistently to all purchasers and members

1 within the HealthMart and shall not be based  
2 in any manner on health status-related factors  
3 and may not conflict with sections 2701 and  
4 2702 of this Act.

5 “(3) HEALTH INSURANCE ISSUERS.—

6 “(A) PREMIUM COLLECTION.—The con-  
7 tract between a HealthMart and a health insur-  
8 ance issuer shall provide, with respect to a  
9 member enrolled with health benefits coverage  
10 offered by the issuer through the HealthMart,  
11 for the payment of the premiums collected by  
12 the HealthMart (or the issuer) for such cov-  
13 erage (less a pre-determined administrative  
14 charge negotiated by the HealthMart and the  
15 issuer) to the issuer.

16 “(B) SCOPE OF SERVICE AREA.—Nothing  
17 in this title shall be construed as requiring the  
18 service area of a health insurance issuer with  
19 respect to health insurance coverage to cover  
20 the entire geographic area served by a  
21 HealthMart.

22 “(C) AVAILABILITY OF COVERAGE OP-  
23 TIONS.—A HealthMart shall enter into con-  
24 tracts with one or more health insurance issuers  
25 in a manner that assures that at least 2 health

1 insurance coverage options are made available  
2 in the geographic area specified under sub-  
3 section (a)(3)(A).

4 “(d) PREVENTION OF CONFLICTS OF INTEREST.—

5 “(1) FOR BOARDS OF DIRECTORS.—A member  
6 of a board of directors of a HealthMart may not  
7 serve as an employee or paid consultant to the  
8 HealthMart, but may receive reasonable reimburse-  
9 ment for travel expenses for purposes of attending  
10 meetings of the board or committees thereof.

11 “(2) FOR BOARDS OF DIRECTORS OR EMPLOY-  
12 EES.—An individual is not eligible to serve in a paid  
13 or unpaid capacity on the board of directors of a  
14 HealthMart or as an employee of the HealthMart, if  
15 the individual is employed by, represents in any ca-  
16 pacity, owns, or controls any ownership interest in  
17 a organization from whom the HealthMart receives  
18 contributions, grants, or other funds not connected  
19 with a contract for coverage through the  
20 HealthMart.

21 “(3) EMPLOYMENT AND EMPLOYEE REP-  
22 REPRESENTATIVES.—

23 “(A) IN GENERAL.—An individual who is  
24 serving on a board of directors of a HealthMart  
25 as a representative described in subparagraph



1 (A) or (B) of section 2801(a)(1) shall not be  
2 employed by or affiliated with a health insur-  
3 ance issuer or be licensed as or employed by or  
4 affiliated with a health care provider.

5 “(B) CONSTRUCTION.—For purposes of  
6 subparagraph (A), the term “affiliated” does  
7 not include membership in a health benefits  
8 plan or the obtaining of health benefits cov-  
9 erage offered by a health insurance issuer.

10 “(e) CONSTRUCTION.—

11 “(1) NETWORK OF AFFILIATED  
12 HEALTHMARTS.—Nothing in this section shall be  
13 construed as preventing one or more HealthMarts  
14 serving different areas (whether or not contiguous)  
15 from providing for some or all of the following  
16 (through a single administrative organization or oth-  
17 erwise):

18 “(A) Coordinating the offering of the same  
19 or similar health benefits coverage in different  
20 areas served by the different HealthMarts.

21 “(B) Providing for crediting of deductibles  
22 and other cost-sharing for individuals who are  
23 provided health benefits coverage through the  
24 HealthMarts (or affiliated HealthMarts)  
25 after—

1                   “(i) a change of employers through  
2                   which the coverage is provided, or

3                   “(ii) a change in place of employment  
4                   to an area not served by the previous  
5                   HealthMart.

6                   “(2) PERMITTING HEALTHMARTS TO ADJUST  
7                   DISTRIBUTIONS AMONG ISSUERS TO REFLECT REL-  
8                   ATIVE RISK OF ENROLLEES.—Nothing in this sec-  
9                   tion shall be construed as precluding a HealthMart  
10                  from providing for adjustments in amounts distrib-  
11                  uted among the health insurance issuers offering  
12                  health benefits coverage through the HealthMart  
13                  based on factors such as the relative health care risk  
14                  of members enrolled under the coverage offered by  
15                  the different issuers.

16                  “(3) APPLICATION OF UNIFORM MINIMUM PAR-  
17                  TICIPATION AND CONTRIBUTION RULES.—Nothing  
18                  in this section shall be construed as precluding a  
19                  HealthMart from establishing minimum participa-  
20                  tion and contribution rules (described in section  
21                  2711(e)(1)) for small employers that apply to be-  
22                  come purchasers in the HealthMart, so long as such  
23                  rules are applied uniformly for all health insurance  
24                  issuers.

1   **“SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIRE-**  
2                           **MENTS.**

3           “(a) **AUTHORITY OF STATES.**—Nothing in this sec-  
4   tion shall be construed as preempting State laws relating  
5   to the following:

6           “(1) The regulation of underwriters of health  
7   coverage, including licensure and solvency require-  
8   ments.

9           “(2) The application of premium taxes and re-  
10   quired payments for guaranty funds or for contribu-  
11   tions to high-risk pools.

12           “(3) The application of fair marketing require-  
13   ments and other consumer protections (other than  
14   those specifically relating to an item described in  
15   subsection (b)).

16           “(4) The application of requirements relating to  
17   the adjustment of rates for health insurance cov-  
18   erage.

19           “(b) **TREATMENT OF BENEFIT AND GROUPING RE-**  
20   **QUIREMENTS.**—State laws insofar as they relate to any  
21   of the following are superseded and shall not apply to  
22   health benefits coverage made available through a  
23   HealthMart:

24           “(1) Benefit requirements for health benefits  
25   coverage offered through a HealthMart, including  
26   (but not limited to) requirements relating to cov-

1        erage of specific providers, specific services or condi-  
2        tions, or the amount, duration, or scope of benefits,  
3        but not including requirements to the extent re-  
4        quired to implement title XXVII or other Federal  
5        law and to the extent the requirement prohibits an  
6        exclusion of a specific disease from such coverage.

7            “(2) Requirements (commonly referred to as  
8        fictitious group laws) relating to grouping and simi-  
9        lar requirements for such coverage to the extent  
10       such requirements impede the establishment and op-  
11       eration of HealthMarts pursuant to this title.

12           “(3) Any other requirements (including limita-  
13       tions on compensation arrangements) that, directly  
14       or indirectly, preclude (or have the effect of preclud-  
15       ing) the offering of such coverage through a  
16       HealthMart, if the HealthMart meets the require-  
17       ments of this title.

18 Any State law or regulation relating to the composition  
19 or organization of a HealthMart is preempted to the ex-  
20 tent the law or regulation is inconsistent with the provi-  
21 sions of this title.

22           “(c) APPLICATION OF ERISA FIDUCIARY AND DIS-  
23 CLOSURE REQUIREMENTS.—The board of directors of a  
24 HealthMart is deemed to be a plan administrator of an  
25 employee welfare benefit plan which is a group health plan

1 for purposes of applying parts 1 and 4 of subtitle B of  
2 title I of the Employee Retirement Income Security Act  
3 of 1974 and those provisions of part 5 of such subtitle  
4 which are applicable to enforcement of such parts 1 and  
5 4, and the HealthMart shall be treated as such a plan  
6 and the enrollees shall be treated as participants and bene-  
7 ficiaries for purposes of applying such provisions pursuant  
8 to this subsection.

9 “(d) APPLICATION OF ERISA RENEWABILITY PRO-  
10 TECTION.—A HealthMart is deemed to be group health  
11 plan that is a multiple employer welfare arrangement for  
12 purposes of applying section 703 of the Employee Retire-  
13 ment Income Security Act of 1974.

14 “(e) APPLICATION OF RULES FOR NETWORK PLANS  
15 AND FINANCIAL CAPACITY.—The provisions of sub-  
16 sections (c) and (d) of section 2711 apply to health bene-  
17 fits coverage offered by a health insurance issuer through  
18 a HealthMart.

19 “(f) CONSTRUCTION RELATING TO OFFERING RE-  
20 QUIREMENT.—Nothing in section 2711(a) of this Act or  
21 703 of the Employee Retirement Income Security Act of  
22 1974 shall be construed as permitting the offering outside  
23 the HealthMart of health benefits coverage that is only  
24 made available through a HealthMart under this section  
25 because of the application of subsection (b).

1       “(g) APPLICATION TO GUARANTEED RENEWABILITY  
2 REQUIREMENTS IN CASE OF DISCONTINUATION OF AN  
3 ISSUER.—For purposes of applying section 2712 in the  
4 case of health insurance coverage offered by a health in-  
5 surance issuer through a HealthMart, if the contract be-  
6 tween the HealthMart and the issuer is terminated and  
7 the HealthMart continues to make available any health in-  
8 surance coverage after the date of such termination, the  
9 following rules apply:

10           “(1) RENEWABILITY.—The HealthMart shall  
11 fulfill the obligation under such section of the issuer  
12 renewing and continuing in force coverage by offer-  
13 ing purchasers (and members and their dependents)  
14 all available health benefits coverage that would oth-  
15 erwise be available to similarly-situated purchasers  
16 and members from the remaining participating  
17 health insurance issuers in the same manner as  
18 would be required of issuers under section 2712(c).

19           “(2) APPLICATION OF ASSOCIATION RULES.—  
20 The HealthMart shall be considered an association  
21 for purposes of applying section 2712(e).

22       “(h) CONSTRUCTION IN RELATION TO CERTAIN  
23 OTHER LAWS.—Nothing in this title shall be construed  
24 as modifying or affecting the applicability to HealthMarts  
25 or health benefits coverage offered by a health insurance

1 issuer through a HealthMart of parts 6 and 7 of subtitle  
 2 B of title I of the Employee Retirement Income Security  
 3 Act of 1974 or titles XXII and XXVII of this Act.

4 **“SEC. 2803. ADMINISTRATION.**

5       “(a) IN GENERAL.—The applicable Federal authority  
 6 shall administer this title through the division established  
 7 under subsection (b) and is authorized to issue such regu-  
 8 lations as may be required to carry out this title. Such  
 9 regulations shall be subject to Congressional review under  
 10 the provisions of chapter 8 of title 5, United States Code.  
 11 The applicable Federal authority shall incorporate the  
 12 process of ‘deemed file and use’ with respect to the infor-  
 13 mation filed under section 2801(a)(6)(A) and shall deter-  
 14 mine whether information filed by a HealthMart dem-  
 15 onstrates compliance with the applicable requirements of  
 16 this title. Such authority shall exercise its authority under  
 17 this title in a manner that fosters and promotes the devel-  
 18 opment of HealthMarts in order to improve access to  
 19 health care coverage and services.

20       “(b) ADMINISTRATION THROUGH HEALTH CARE  
 21 MARKETPLACE DIVISION.—

22       “(1) IN GENERAL.—The applicable Federal au-  
 23 thority shall carry out its duties under this title  
 24 through a separate Health Care Marketplace Divi-

1        sion, the sole duty of which (including the staff of  
2        which) shall be to administer this title.

3            “(2) **ADDITIONAL DUTIES.**—In addition to  
4        other responsibilities provided under this title, such  
5        Division is responsible for—

6            “(A) oversight of the operations of  
7        HealthMarts under this title; and

8            “(B) the periodic submittal to Congress of  
9        reports on the performance of HealthMarts  
10       under this title under subsection (c).

11       “(c) **PERIODIC REPORTS.**—The applicable Federal  
12       authority shall submit to Congress a report every 30  
13       months, during the 10-year period beginning on the effec-  
14       tive date of the rules promulgated by the applicable Fed-  
15       eral authority to carry out this title, on the effectiveness  
16       of this title in promoting coverage of uninsured individ-  
17       uals. Such authority may provide for the production of  
18       such reports through one or more contracts with appro-  
19       priate private entities.

20       **“SEC. 2804. DEFINITIONS.**

21       “For purposes of this title:

22            “(1) **APPLICABLE FEDERAL AUTHORITY.**—The  
23       term ‘applicable Federal authority’ means the Sec-  
24       retary of Health and Human Services .



1           “(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—

2           The term ‘eligible’ means, with respect to an em-  
3           ployee or other individual and a HealthMart, an em-  
4           ployee or individual who is eligible under section  
5           2801(c)(2) to enroll or be enrolled in health benefits  
6           coverage offered through the HealthMart.

7           “(3) EMPLOYER; EMPLOYEE; DEPENDENT.—

8           Except as the applicable Federal authority may oth-  
9           erwise provide, the terms ‘employer’, ‘employee’, and  
10          ‘dependent’, as applied to health insurance coverage  
11          offered by a health insurance issuer licensed (or oth-  
12          erwise regulated) in a State, shall have the meanings  
13          applied to such terms with respect to such coverage  
14          under the laws of the State relating to such coverage  
15          and such an issuer.

16          “(4) HEALTH BENEFITS COVERAGE.—The term  
17          ‘health benefits coverage’ has the meaning given the  
18          term group health insurance coverage in section  
19          2791(b)(4).

20          “(5) HEALTH INSURANCE ISSUER.—The term  
21          ‘health insurance issuer’ has the meaning given such  
22          term in section 2791(b)(2) and includes a commu-  
23          nity health organization that is offering coverage  
24          pursuant to section 330B(a).

1 “(6) HEALTH STATUS-RELATED FACTOR.—The  
 2 term ‘health status-related factor’ has the meaning  
 3 given such term in section 2791(d)(9).

4 “(7) HEALTHMART.—The term ‘HealthMart’ is  
 5 defined in section 2801(a).

6 “(8) MEMBER.—The term ‘member’ means,  
 7 with respect to a HealthMart, an individual enrolled  
 8 for health benefits coverage through the HealthMart  
 9 under section 2801(c)(2).

10 “(9) PURCHASER.—The term ‘purchaser’  
 11 means, with respect to a HealthMart, a small em-  
 12 ployer that has contracted under section  
 13 2801(c)(1)(A) with the HealthMart for the purchase  
 14 of health benefits coverage.

15 “(10) SMALL EMPLOYER.—The term ‘small em-  
 16 ployer’ has the meaning given such term for pur-  
 17 poses of title XXVII.”.

## 18 **Subtitle D—Community Health** 19 **Organizations**

### 20 **SEC. 2301. PROMOTION OF PROVISION OF INSURANCE BY** 21 **COMMUNITY HEALTH ORGANIZATIONS.**

22 (a) WAIVER OF STATE LICENSURE REQUIREMENT  
 23 FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN  
 24 CASES.—Subpart I of part D of title III of the Public

1 Health Service Act is amended by adding at the end the  
2 following new section:

3 “WAIVER OF STATE LICENSURE REQUIREMENT FOR  
4 COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

5 “SEC. 330B. (a) WAIVER AUTHORIZED.—

6 “(1) IN GENERAL.—A community health orga-  
7 nization may offer health insurance coverage in a  
8 State notwithstanding that it is not licensed in such  
9 a State to offer such coverage if—

10 “(A) the organization files an application  
11 for waiver of the licensure requirement with the  
12 Secretary of Health and Human Services (in  
13 this section referred to as the ‘Secretary’) by  
14 not later than November 1, 2003, and

15 “(B) the Secretary determines, based on  
16 the application and other evidence presented to  
17 the Secretary, that any of the grounds for ap-  
18 proval of the application described in subpara-  
19 graph (A), (B), or (C) of paragraph (2) has  
20 been met.

21 “(2) GROUNDS FOR APPROVAL OF WAIVER.—

22 “(A) FAILURE TO ACT ON LICENSURE AP-  
23 PPLICATION ON A TIMELY BASIS.—The ground  
24 for approval of such a waiver application de-  
25 scribed in this subparagraph is that the State  
26 has failed to complete action on a licensing ap-

1           plication of the organization within 90 days of  
2           the date of the State’s receipt of a substantially  
3           complete application. No period before the date  
4           of the enactment of this section shall be in-  
5           cluded in determining such 90-day period.

6           “(B) DENIAL OF APPLICATION BASED ON  
7           DISCRIMINATORY TREATMENT.—The ground for  
8           approval of such a waiver application described  
9           in this subparagraph is that the State has de-  
10          nied such a licensing application and the stand-  
11          ards or review process imposed by the State as  
12          a condition of approval of the license or as the  
13          basis for such denial by the State imposes any  
14          material requirements, procedures, or standards  
15          (other than solvency requirements) to such or-  
16          ganizations that are not generally applicable to  
17          other entities engaged in a substantially similar  
18          business.

19          “(C) DENIAL OF APPLICATION BASED ON  
20          APPLICATION OF SOLVENCY REQUIREMENTS.—  
21          With respect to waiver applications filed on or  
22          after the date of publication of solvency stand-  
23          ards established by the Secretary under sub-  
24          section (d), the ground for approval of such a  
25          waiver application described in this subpara-

graph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable State solvency requirements and such requirements are not the same as the solvency standards established by the Secretary. For purposes of this subparagraph, the term solvency requirements means requirements relating to solvency and other matters covered under the standards established by the Secretary under subsection (d).

“(3) TREATMENT OF WAIVER.—In the case of a waiver granted under this subsection for a community health organization with respect to a State—

“(A) LIMITATION TO STATE.—The waiver shall be effective only with respect to that State and does not apply to any other State.

“(B) LIMITATION TO 36-MONTH PERIOD.—The waiver shall be effective only for a 36-month period but may be renewed for up to 36 additional months if the Secretary determines that such an extension is appropriate.

“(C) CONDITIONED ON COMPLIANCE WITH CONSUMER PROTECTION AND QUALITY STANDARDS.—The continuation of the waiver is condi-

tioned upon the organization's compliance with the requirements described in paragraph (5).

“(D) PREEMPTION OF STATE LAW.—Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing health insurance coverage shall be superseded.

“(4) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

“(5) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—A waiver granted under this subsection to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

“(A) would apply in the State to the community health organization if it were licensed as

1           an entity offering health insurance coverage  
2           under State law; and

3                 “(B) are generally applicable to other risk-  
4           bearing managed care organizations and plans  
5           in the State.

6                 “(6) REPORT.—By not later than December 31,  
7           2002, the Secretary shall submit to the Committee  
8           on Commerce of the House of Representatives and  
9           the Committee on Labor and Human Resources of  
10          the Senate a report regarding whether the waiver  
11          process under this subsection should be continued  
12          after December 31, 2003.

13                “(b) ASSUMPTION OF FULL FINANCIAL RISK.—To  
14          qualify for a waiver under subsection (a), the community  
15          health organization shall assume full financial risk on a  
16          prospective basis for the provision of covered health care  
17          services, except that the organization—

18                   “(1) may obtain insurance or make other ar-  
19           rangements for the cost of providing to any enrolled  
20           member such services the aggregate value of which  
21           exceeds such aggregate level as the Secretary speci-  
22           fies from time to time;

23                   “(2) may obtain insurance or make other ar-  
24           rangements for the cost of such services provided to  
25           its enrolled members other than through the organi-

1        zation because medical necessity required their pro-  
2        vision before they could be secured through the orga-  
3        nization;

4            “(3) may obtain insurance or make other ar-  
5        rangements for not more than 90 percent of the  
6        amount by which its costs for any of its fiscal years  
7        exceed 105 percent of its income for such fiscal year;  
8        and

9            “(4) may make arrangements with physicians  
10       or other health care professionals, health care insti-  
11       tutions, or any combination of such individuals or  
12       institutions to assume all or part of the financial  
13       risk on a prospective basis for the provision of  
14       health services by the physicians or other health pro-  
15       fessionals or through the institutions.

16       “(c) CERTIFICATION OF PROVISION AGAINST RISK OF  
17       INSOLVENCY FOR UNLICENSED CHOs.—

18            “(1) IN GENERAL.—Each community health or-  
19       ganization that is not licensed by a State and for  
20       which a waiver application has been approved under  
21       subsection (a)(1), shall meet standards established  
22       by the Secretary under subsection (d) relating to the  
23       financial solvency and capital adequacy of the orga-  
24       nization.



1           “(2) CERTIFICATION PROCESS FOR SOLVENCY  
2           STANDARDS FOR CHOS.—The Secretary shall estab-  
3           lish a process for the receipt and approval of appli-  
4           cations of a community health organization de-  
5           scribed in paragraph (1) for certification (and peri-  
6           odic recertification) of the organization as meeting  
7           such solvency standards. Under such process, the  
8           Secretary shall act upon such a certification applica-  
9           tion not later than 60 days after the date the appli-  
10          cation has been received.

11          “(d) ESTABLISHMENT OF SOLVENCY STANDARDS  
12          FOR COMMUNITY HEALTH ORGANIZATIONS.—

13               “(1) IN GENERAL.—The Secretary shall estab-  
14               lish, on an expedited basis and by rule pursuant to  
15               section 553 of title 5, United States Code and  
16               through the Health Resources and Services Adminis-  
17               tration, standards described in subsection (c)(1) (re-  
18               lating to financial solvency and capital adequacy)  
19               that entities must meet to obtain a waiver under  
20               subsection (a)(2)(C). In establishing such standards,  
21               the Secretary shall consult with interested organiza-  
22               tions, including the National Association of Insur-  
23               ance Commissioners, the Academy of Actuaries, and  
24               organizations representing Federally qualified health  
25               centers.

1           “(2) FACTORS TO CONSIDER FOR SOLVENCY  
2           STANDARDS.—In establishing solvency standards for  
3           community health organizations under paragraph  
4           (1), the Secretary shall take into account—

5                   “(A) the delivery system assets of such an  
6                   organization and ability of such an organization  
7                   to provide services to enrollees;

8                   “(B) alternative means of protecting  
9                   against insolvency, including reinsurance, unre-  
10                  stricted surplus, letters of credit, guarantees,  
11                  organizational insurance coverage, partnerships  
12                  with other licensed entities, and valuation at-  
13                  tributable to the ability of such an organization  
14                  to meet its service obligations through direct  
15                  delivery of care; and

16                  “(C) any standards developed by the Na-  
17                  tional Association of Insurance Commissioners  
18                  specifically for risk-based health care delivery  
19                  organizations.

20           “(3) ENROLLEE PROTECTION AGAINST INSOL-  
21           VENCY.—Such standards shall include provisions to  
22           prevent enrollees from being held liable to any per-  
23           son or entity for the organization’s debts in the  
24           event of the organization’s insolvency.

1           “(4) DEADLINE.—Such standards shall be pro-  
2           mulgated in a manner so they are first effective by  
3           not later than April 1, 1999.

4           “(e) DEFINITIONS.—In this section:

5           “(1) COMMUNITY HEALTH ORGANIZATION.—  
6           The term ‘community health organization ’ means  
7           an organization that is a Federally-qualified health  
8           center or is controlled by one or more Federally-  
9           qualified health centers.

10          “(2) FEDERALLY-QUALIFIED HEALTH CEN-  
11          TER.—The term ‘Federally-qualified health center’  
12          has the meaning given such term in section  
13          1905(l)(2)(B) of the Social Security Act.

14          “(3) HEALTH INSURANCE COVERAGE.—The  
15          term ‘health insurance coverage’ has the meaning  
16          given such term in section 2791(b)(1).

17          “(4) CONTROL.—The term ‘control’ means the  
18          possession, whether direct or indirect, of the power  
19          to direct or cause the direction of the management  
20          and policies of the organization through member-  
21          ship, board representation, or an ownership interest  
22          equal to or greater than 50.1 percent.”.

1 **TITLE III—AMENDMENTS TO**  
2 **THE INTERNAL REVENUE**  
3 **CODE OF 1986**

4 **Subtitle A—Patient Protections**

5 **SEC. 3001. PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
6 **ADVICE, EMERGENCY MEDICAL CARE, OB-**  
7 **STETRIC AND GYNECOLOGICAL CARE, PEDI-**  
8 **ATRIC CARE.**

9 (a) IN GENERAL.—Subchapter B of chapter 100 of  
10 the Internal Revenue Code of 1986 (relating to other re-  
11 quirements) is amended by adding at the end the following  
12 new section:

13 **“SEC. 9813. PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
14 **ADVICE, EMERGENCY MEDICAL CARE, OB-**  
15 **STETRIC AND GYNECOLOGICAL CARE, PEDI-**  
16 **ATRIC CARE.**

17 **“(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
18 **ADVICE.—**

19 **“(1) IN GENERAL.—**In the case of any health  
20 care professional acting within the lawful scope of  
21 practice in the course of carrying out a contractual  
22 employment arrangement or other direct contractual  
23 arrangement between such professional and a group  
24 health plan, the plan with which such contractual  
25 employment arrangement or other direct contractual

1 arrangement is maintained by the professional may  
2 not impose on such professional under such arrange-  
3 ment any prohibition with respect to advice, pro-  
4 vided to a participant or beneficiary under the plan  
5 who is a patient, about the health status of the par-  
6 ticipant or beneficiary or the medical care or treat-  
7 ment for the condition or disease of the participant  
8 or beneficiary, regardless of whether benefits for  
9 such care or treatment are provided under the plan.

10 “(2) HEALTH CARE PROFESSIONAL DEFINED.—

11 For purposes of this subsection, the term ‘health  
12 care professional’ means a physician (as defined in  
13 section 1861(r) of the Social Security Act) or other  
14 health care professional if coverage for the profes-  
15 sional’s services is provided under the group health  
16 plan for the services of the professional. Such term  
17 includes a podiatrist, optometrist, chiropractor, psy-  
18 chologist, dentist, physician assistant, physical or oc-  
19 cupational therapist and therapy assistant, speech-  
20 language pathologist, audiologist, registered or li-  
21 censed practical nurse (including nurse practitioner,  
22 clinical nurse specialist, certified registered nurse  
23 anesthetist, and certified nurse–midwife), licensed  
24 certified social worker, registered respiratory thera-  
25 pist, and certified respiratory therapy technician.

1       “(b) PATIENT ACCESS TO EMERGENCY MEDICAL  
2 CARE.—

3               “(1) IN GENERAL.—To the extent that the  
4 group health plan provides for any benefits consist-  
5 ing of emergency medical care (as defined in section  
6 503(b)(9)(I) of the Employee Retirement Income Se-  
7 curity Act of 1974), except for items or services spe-  
8 cifically excluded—

9               “(A) the plan shall provide benefits, with-  
10 out requiring preauthorization, for appropriate  
11 emergency medical screening examinations  
12 (within the capability of the emergency facility,  
13 including ancillary services routinely available  
14 to the emergency facility) to the extent that a  
15 prudent layperson, who possesses an average  
16 knowledge of health and medicine, would deter-  
17 mine such examinations to be necessary in  
18 order to determine whether emergency medical  
19 care (as so defined) is required, and

20               “(B) the plan shall provide benefits for ad-  
21 ditional emergency medical services following an  
22 emergency medical screening examination (if  
23 determined necessary under subparagraph (A))  
24 to the extent that a prudent emergency medical  
25 professional would determine such additional

1 emergency services to be necessary to avoid the  
2 consequences described in clause (i) of section  
3 503(b)(9)(I) of such Act.

4 “(2) UNIFORM COST-SHARING REQUIRED.—  
5 Nothing in this subsection shall be construed as pre-  
6 venting a group health plan from imposing any form  
7 of cost-sharing applicable to any participant or bene-  
8 ficiary (including coinsurance, copayments,  
9 deductibles, and any other charges) in relation to  
10 benefits described in paragraph (1), if such form of  
11 cost-sharing is uniformly applied under such plan,  
12 with respect to similarly situated participants and  
13 beneficiaries, to all benefits consisting of emergency  
14 medical care (as defined in section 503(b)(9)(I) of  
15 the Employee Retirement Income Security Act of  
16 1974) provided to such similarly situated partici-  
17 pants and beneficiaries under the plan.

18 “(c) PATIENT ACCESS TO OBSTETRIC AND GYNECO-  
19 LOGICAL CARE.

20 “(1) IN GENERAL.—In any case in which a  
21 group health plan—

22 “(A) provides benefits under the terms of  
23 the plan consisting of—

1                   “(i) routine gynecological care (such  
2                   as preventive women’s health examina-  
3                   tions), or

4                   “(ii) routine obstetric care (such as  
5                   routine pregnancy-related services),  
6                   provided by a participating physician who spe-  
7                   cializes in such care (or provides benefits con-  
8                   sisting of payment for such care), and

9                   “(B) the plan requires or provides for des-  
10                  ignation by a participant or beneficiary of a  
11                  participating primary care provider,

12               if the primary care provider designated by such a  
13               participant or beneficiary is not such a physician,  
14               then the plan shall meet the requirements of para-  
15               graph (2).

16               “(2) REQUIREMENTS.—A group health plan  
17               meets the requirements of this paragraph, in connec-  
18               tion with benefits described in paragraph (1) con-  
19               sisting of care described in clause (i) or (ii) of para-  
20               graph (1)(A) (or consisting of payment therefor), if  
21               the plan—

22               “(A) does not require authorization or a  
23               referral by the primary care provider in order  
24               to obtain such benefits, and



1           “(B) treats the ordering of other routine  
2           care of the same type, by the participating phy-  
3           sician providing the care described in clause (i)  
4           or (ii) of paragraph (1)(A), as the authorization  
5           of the primary care provider with respect to  
6           such care.

7           “(3) CONSTRUCTION.—Nothing in paragraph  
8           (2)(B) shall waive any requirements of coverage re-  
9           lating to medical necessity or appropriateness with  
10          respect to coverage of gynecological or obstetric care  
11          so ordered.

12          “(d) PATIENT ACCESS TO PEDIATRIC CARE.—

13               “(1) IN GENERAL.—In any case in which a  
14               group health plan (or a health insurance issuer of-  
15               fering health insurance coverage in connection with  
16               the plan) provides benefits consisting of routine pe-  
17               diatric care provided by a participating physician  
18               who specializes in pediatrics (or consisting of pay-  
19               ment for such care) and the plan requires or pro-  
20               vides for designation by a participant or beneficiary  
21               of a participating primary care provider, the plan (or  
22               issuer) shall provide that such a participating physi-  
23               cian may be designated, if available, by a parent or  
24               guardian of any beneficiary under the plan is who

1 under 18 years of age, as the primary care provider  
 2 with respect to any such benefits.

3 “(2) CONSTRUCTION.—Nothing in paragraph  
 4 (1) shall waive any requirements of coverage relating  
 5 to medical necessity or appropriateness with respect  
 6 to coverage of pediatric care.

7 “(e) TREATMENT OF MULTIPLE COVERAGE OP-  
 8 TIONS.—In the case of a plan providing benefits under two  
 9 or more coverage options, the requirements of subsections  
 10 (c) and (d) shall apply separately with respect to each cov-  
 11 erage option.”.

12 (b) CLERICAL AMENDMENT.—The table of sections  
 13 of such subchapter of such chapter is amended by adding  
 14 at the end the following new item:

“Sec. 9813. Patient access to unrestricted medical advice, emer-  
 gency medical care, obstetric and gynecological  
 care, pediatric care.”

15 **SEC. 3002. EFFECTIVE DATE AND RELATED RULES.**

16 (a) IN GENERAL.—The amendments made by this  
 17 subtitle shall apply with respect to plan years beginning  
 18 on or after January 1 of the second calendar year follow-  
 19 ing the date of the enactment of this Act, except that the  
 20 Secretary of the Treasury may issue regulations before  
 21 such date under such amendments. The Secretary shall  
 22 first issue regulations necessary to carry out the amend-  
 23 ments made by this section before the effective date there-  
 24 of.

1       (b) LIMITATION ON PENALTY FOR CERTAIN FAIL-  
2 URES.—No penalty shall be imposed on any failure to  
3 comply with any requirement imposed by the amendments  
4 made by section 3101 to the extent such failure occurs  
5 before the date of issuance of regulations issued in connec-  
6 tion with such requirement if the plan has sought to com-  
7 ply in good faith with such requirement.

8       (c) SPECIAL RULE FOR COLLECTIVE BARGAINING  
9 AGREEMENTS.—In the case of a group health plan main-  
10 tained pursuant to one or more collective bargaining  
11 agreements between employee representatives and one or  
12 more employers ratified before the date of the enactment  
13 of this Act, the provisions of subsections (b), (c), and (d)  
14 of section 9813 of the Internal Revenue Code of 1986 (as  
15 added by this subtitle) shall not apply with respect to plan  
16 years beginning before the later of—

17           (1) the date on which the last of the collective  
18 bargaining agreements relating to the plan termi-  
19 nates (determined without regard to any extension  
20 thereof agreed to after the date of the enactment of  
21 this Act), or

22           (2) January 1, 2001.

23       For purposes of this subsection, any plan amend-  
24 ment made pursuant to a collective bargaining  
25 agreement relating to the plan which amends the

1 plan solely to conform to any requirement added by  
 2 this subtitle shall not be treated as a termination of  
 3 such collective bargaining agreement.

## 4 **Subtitle B—Patient Access to** 5 **Information**

### 6 **SEC. 3101. PATIENT ACCESS TO INFORMATION REGARDING** 7 **PLAN COVERAGE, MANAGED CARE PROCE-** 8 **DURES, HEALTH CARE PROVIDERS, AND** 9 **QUALITY OF MEDICAL CARE.**

10 (a) IN GENERAL.—Subchapter B of chapter 100 of  
 11 the Internal Revenue Code of 1986 (relating to other re-  
 12 quirements) is amended by adding at the end the following  
 13 new section:

#### 14 **“SEC. 9814. DISCLOSURE BY GROUP HEALTH PLANS.**

15 “(a) DISCLOSURE REQUIREMENT.—The adminis-  
 16 trator of each group health plan shall take such actions  
 17 as are necessary to ensure that the summary plan descrip-  
 18 tion of the plan required under section 102 of Employee  
 19 Retirement Income Security Act of 1974 (or each sum-  
 20 mary plan description in any case in which different sum-  
 21 mary plan descriptions are appropriate under part 1 of  
 22 subtitle B of title I of such Act for different options of  
 23 coverage) contains the information required under sub-  
 24 sections (b), (c), (d), and (e)(2)(A). To the extent that  
 25 any health insurance issuer offering health insurance cov-

1 erage in connection with such plan provides such informa-  
2 tion on a timely basis to plan participants and bene-  
3 ficiaries, the requirements of this subsection shall be  
4 deemed satisfied in the case of such plan with respect to  
5 such information.

6 “(b) PLAN BENEFITS.—The information required  
7 under subsection (a) includes the following:

8 “(1) COVERED ITEMS AND SERVICES.—

9 “(A) CATEGORIZATION OF INCLUDED BEN-  
10 EFITS.—A description of covered benefits, cat-  
11 egorized by—

12 “(i) types of items and services (in-  
13 cluding any special disease management  
14 program), and

15 “(ii) types of health care professionals  
16 providing such items and services.

17 “(B) EMERGENCY MEDICAL CARE.—A de-  
18 scription of the extent to which the plan covers  
19 emergency medical care (including the extent to  
20 which the plan provides for access to urgent  
21 care centers), and any definitions provided  
22 under the plan for the relevant plan terminol-  
23 ogy referring to such care.

1           “(C) PREVENTATIVE SERVICES.—A de-  
2           scription of the extent to which the plan pro-  
3           vides benefits for preventative services.

4           “(D) DRUG FORMULARIES.—A description  
5           of the extent to which covered benefits are de-  
6           termined by the use or application of a drug  
7           formulary and a summary of the process for de-  
8           termining what is included in such formulary.

9           “(E) COBRA CONTINUATION COV-  
10          ERAGE.—A description of the requirements  
11          under section 4980B.

12          “(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-  
13          TIONS ON COVERED BENEFITS.—

14               “(A) CATEGORIZATION OF EXCLUDED  
15               BENEFITS.—A description of benefits specifi-  
16               cally excluded from coverage, categorized by  
17               types of items and services.

18               “(B) UTILIZATION REVIEW AND  
19               PREAUTHORIZATION REQUIREMENTS.—Whether  
20               coverage for medical care is limited or excluded  
21               on the basis of utilization review or  
22               preauthorization requirements.

23               “(C) LIFETIME, ANNUAL, OR OTHER PE-  
24               RIOD LIMITATIONS.—A description of the cir-  
25               cumstances under which, and the extent to

1 which, coverage is subject to lifetime, annual, or  
2 other period limitations, categorized by types of  
3 benefits.

4 “(D) CUSTODIAL CARE.—A description of  
5 the circumstances under which, and the extent  
6 to which, the coverage of benefits for custodial  
7 care is limited or excluded, and a statement of  
8 the definition used by the plan for custodial  
9 care.

10 “(E) EXPERIMENTAL TREATMENTS.—  
11 Whether coverage for any medical care is lim-  
12 ited or excluded because it constitutes experi-  
13 mental treatment or technology, and any defini-  
14 tions provided under the plan for the relevant  
15 plan terminology referring to such limited or  
16 excluded care.

17 “(F) MEDICAL APPROPRIATENESS OR NE-  
18 CESSITY.—Whether coverage for medical care  
19 may be limited or excluded by reason of a fail-  
20 ure to meet the plan’s requirements for medical  
21 appropriateness or necessity, and any defini-  
22 tions provided under the plan for the relevant  
23 plan terminology referring to such limited or  
24 excluded care.

1           “(G) SECOND OR SUBSEQUENT OPIN-  
2 IONS.—A description of the circumstances  
3 under which, and the extent to which, coverage  
4 for second or subsequent opinions is limited or  
5 excluded.

6           “(H) SPECIALTY CARE.—A description of  
7 the circumstances under which, and the extent  
8 to which, coverage of benefits for specialty care  
9 is conditioned on referral from a primary care  
10 provider.

11           “(I) CONTINUITY OF CARE.—A description  
12 of the circumstances under which, and the ex-  
13 tent to which, coverage of items and services  
14 provided by any health care professional is lim-  
15 ited or excluded by reason of the departure by  
16 the professional from any defined set of provid-  
17 ers.

18           “(J) RESTRICTIONS ON COVERAGE OF  
19 EMERGENCY SERVICES.—A description of the  
20 circumstances under which, and the extent to  
21 which, the plan, in covering emergency medical  
22 care furnished to a participant or beneficiary of  
23 the plan imposes any financial responsibility de-  
24 scribed in subsection (c) on participants or  
25 beneficiaries or limits or conditions benefits for



1           such care subject to any other term or condition  
2           of such plan.

3           “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-  
4 ITIES.—The information required under subsection (a) in-  
5 cludes an explanation of—

6           “(1) a participant’s financial responsibility for  
7       payment of premiums, coinsurance, copayments,  
8       deductibles, and any other charges, and

9           “(2) the circumstances under which, and the  
10       extent to which, the participant’s financial respon-  
11       sibility described in paragraph (1) may vary, includ-  
12       ing any distinctions based on whether a health care  
13       provider from whom covered benefits are obtained is  
14       included in a defined set of providers.

15          “(d) DISPUTE RESOLUTION PROCEDURES.—The in-  
16 formation required under subsection (a) includes a de-  
17 scription of the processes adopted by the plan pursuant  
18 to section 503(b) of Employee Retirement Income Secu-  
19 rity Act of 1974, including—

20           “(1) descriptions thereof relating specifically  
21       to—

22                   “(A) coverage decisions,

23                   “(B) internal review of coverage decisions,

24           and

1                   “(C) any external review of coverage deci-  
2                   sions, and

3                   “(2) the procedures and time frames applicable  
4                   to each step of the processes referred to in subpara-  
5                   graphs (A), (B), and (C) of paragraph (1).

6                   “(e) INFORMATION AVAILABLE ON REQUEST.—

7                   “(1) ACCESS TO PLAN BENEFIT INFORMATION  
8                   IN ELECTRONIC FORM.—

9                   “(A) IN GENERAL.—A group health plan  
10                  shall, upon written request (made not more fre-  
11                  quently than annually), make available to par-  
12                  ticipants and beneficiaries, in a generally recog-  
13                  nized electronic format, the following informa-  
14                  tion:

15                  “(i) the latest summary plan descrip-  
16                  tion, including the latest summary of ma-  
17                  terial modifications; and

18                  “(ii) the actual plan provisions setting  
19                  forth the benefits available under the plan  
20                  to the extent such information relates to the  
21                  coverage options under the plan available to the  
22                  participant or beneficiary. A reasonable charge  
23                  may be made to cover the cost of providing  
24                  such information in such generally recognized  
25                  electronic format. The Secretary may by regula-

tion prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

“(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

“(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

“(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

“(B) INFORMATION REQUIRED FROM PLANS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan shall provide the following information to a participant or beneficiary on request:

1                   “(i) NETWORK CHARACTERISTICS.—If  
2                   the plan (or a health insurance issuer of-  
3                   fering health insurance coverage in connec-  
4                   tion with the plan) utilizes a defined set of  
5                   providers under contract with the plan (or  
6                   issuer), a detailed list of the names of such  
7                   providers and their geographic location, set  
8                   forth separately with respect to primary  
9                   care providers and with respect to special-  
10                  ists.

11                  “(ii) CARE MANAGEMENT INFORMA-  
12                  TION.—A description of the circumstances  
13                  under which, and the extent to which, the  
14                  plan has special disease management pro-  
15                  grams or programs for persons with dis-  
16                  abilities, indicating whether these pro-  
17                  grams are voluntary or mandatory and  
18                  whether a significant benefit differential  
19                  results from participation in such pro-  
20                  grams.

21                  “(iii) INCLUSION OF DRUGS AND  
22                  BIOLOGICALS IN FORMULARIES.—A state-  
23                  ment of whether a specific drug or biologi-  
24                  cal is included in a formulary used to de-  
25                  termine benefits under the plan and a de-

1           scription of the procedures for considering  
2           requests for any patient-specific waivers.

3           “(iv) PROCEDURES FOR DETERMINING  
4           EXCLUSIONS BASED ON MEDICAL NECES-  
5           SITY OR EXPERIMENTAL TREATMENTS.—  
6           Upon receipt by the participant or bene-  
7           ficiary of any notification of an adverse  
8           coverage decision based on a determination  
9           relating to medical necessity or an experi-  
10          mental treatment or technology, a descrip-  
11          tion of the procedures and medically-based  
12          criteria used in such decision.

13          “(v) PREAUTHORIZATION AND UTILI-  
14          ZATION REVIEW PROCEDURES.—Upon re-  
15          ceipt by the participant or beneficiary of  
16          any notification of an adverse coverage de-  
17          cision, a description of the basis on which  
18          any preauthorization requirement or any  
19          utilization review requirement has resulted  
20          in such decision.

21          “(vi) ACCREDITATION STATUS OF  
22          HEALTH INSURANCE ISSUERS AND SERV-  
23          ICE PROVIDERS.—A description of the ac-  
24          creditation and licencing status (if any) of  
25          each health insurance issuer offering

1 health insurance coverage in connection  
2 with the plan and of any utilization review  
3 organization utilized by the issuer or the  
4 plan, together with the name and address  
5 of the accrediting or licencing authority.

6 “(vii) MEASURES OF ENROLLEE SAT-  
7 ISFACTION.—The latest information (if  
8 any) maintained by the plan, or by any  
9 health insurance issuer offering health in-  
10 surance coverage in connection with the  
11 plan, relating to enrollee satisfaction.

12 “(viii) QUALITY PERFORMANCE MEAS-  
13 URES.—The latest information (if any)  
14 maintained by the plan, or by any health  
15 insurance issuer offering health insurance  
16 coverage in connection with the plan, relat-  
17 ing to quality of performance of the deliv-  
18 ery of medical care with respect to cov-  
19 erage options offered under the plan and  
20 of health care professionals and facilities  
21 providing medical care under the plan.

22 “(C) INFORMATION REQUIRED FROM  
23 HEALTH CARE PROFESSIONALS ON REQUEST.—  
24 Any health care professional treating a partici-  
25 pant or beneficiary under a group health plan

1 shall provide to the participant or beneficiary,  
2 on request, a description of his or her profes-  
3 sional qualifications (including board certifi-  
4 cation status, licensing status, and accreditation  
5 status, if any), privileges, and experience and a  
6 general description by category (including sal-  
7 ary, fee-for-service, capitation, and such other  
8 categories as may be specified in regulations of  
9 the Secretary) of the applicable method by  
10 which such professional is compensated in con-  
11 nection with the provision of such medical care.

12 “(D) INFORMATION REQUIRED FROM  
13 HEALTH CARE FACILITIES ON REQUEST.—Any  
14 health care facility from which a participant or  
15 beneficiary has sought treatment under a group  
16 health plan shall provide to the participant or  
17 beneficiary, on request, a description of the fa-  
18 cility’s corporate form or other organizational  
19 form and all forms of licensing and accredita-  
20 tion status (if any) assigned to the facility by  
21 standard-setting organizations.

22 “(f) ACCESS TO INFORMATION RELEVANT TO THE  
23 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR  
24 BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to  
25 information otherwise required to be made available under

1 this section, a group health plan shall, upon written re-  
2 quest (made not more frequently than annually), make  
3 available to a participant in connection with a period of  
4 enrollment the summary plan description for any coverage  
5 option under the plan under which the participant is eligi-  
6 ble to enroll and any information described in clauses (i),  
7 (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

8 “(g) ADVANCE NOTICE OF CHANGES IN DRUG  
9 FORMULARIES.—Not later than 30 days before the effec-  
10 tive of date of any exclusion of a specific drug or biological  
11 from any drug formulary under the plan that is used in  
12 the treatment of a chronic illness or disease, the plan shall  
13 take such actions as are necessary to reasonably ensure  
14 that plan participants are informed of such exclusion. The  
15 requirements of this subsection may be satisfied—

16 “(1) by inclusion of information in publications  
17 broadly distributed by plan sponsors, employers, or  
18 employee organizations,

19 “(2) by electronic means of communication (in-  
20 cluding the Internet or proprietary computer net-  
21 works in a format which is readily accessible to par-  
22 ticipants),

23 “(3) by timely informing participants who,  
24 under an ongoing program maintained under the



1 plan, have submitted their names for such notifica-  
 2 tion, or

3 “(4) by any other reasonable means of timely  
 4 informing plan participants.”.

5 (b) CLERICAL AMENDMENT.—The table of sections  
 6 of such subchapter of such chapter is amended by adding  
 7 at the end the following new item:

“Sec. 9814. Disclosure by group health plans.”

8 **SEC. 3102. REPORTING ON FRAUD AND ABUSE ENFORCE-**  
 9 **MENT ACTIVITIES.**

10 The General Accounting Office shall—

11 (1) monitor—

12 (A) the compliance of the Department of  
 13 Justice and all United States Attorneys—with  
 14 the guideline entitled “Guidance on the Use of  
 15 the False Claims Act in Civil Health Care Mat-  
 16 ters” issued by the Department on June 3,  
 17 1998, including any revisions to that guideline,  
 18 and

19 (B) the compliance of the Office of the In-  
 20 spector General of the Department of Health  
 21 and Human Services with the protocols and  
 22 guidelines entitled “National Project Proto-  
 23 cols—Best Practice Guidelines” issued by the  
 24 Inspector General on June 3, 1998, including

1           any revisions to such protocols and guidelines,  
2           and

3           (2) submit a report on such compliance to the  
4       Committee on the Judiciary and the Committee on  
5       Ways and Means of the House of Representatives  
6       and the Committee on the Judiciary and the Com-  
7       mittee on Finance of the Senate not later than Feb-  
8       ruary 1, 1999, and every year thereafter for a period  
9       of four years ending February 1, 2002.

10 **SEC. 3103. EFFECTIVE DATE.**

11       (a) IN GENERAL.—The amendments made by this  
12 subtitle shall apply with respect to plan years beginning  
13 on or after January 1 of the second calendar year follow-  
14 ing the date of the enactment of this Act. The Secretary  
15 of the Treasury or the Secretary's delegate shall first issue  
16 all regulations necessary to carry out the amendments  
17 made by this subtitle before such date.

18       (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
19 enforcement action shall be taken, pursuant to the amend-  
20 ments made by this subtitle, against a group health plan  
21 with respect to a violation of a requirement imposed by  
22 such amendments before the date of issuance of final regu-  
23 lations issued in connection with such requirement, if the  
24 plan has sought to comply in good faith with such require-  
25 ment.

## **Subtitle C—Medical Savings Accounts**

### **SEC. 3201. EXPANSION OF AVAILABILITY OF MEDICAL SAV- INGS ACCOUNTS.**

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(b) ALL EMPLOYERS MAY OFFER MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subclause (I) of section 220(c)(1)(A)(iii) of such Code (defining eligible individual) is amended by striking “and such employer is a small employer”.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (C).

(B) Subsection (c) of section 220 of such Code is amended by striking paragraph (4) and

1 by redesignating paragraph (5) as paragraph  
2 (4).

3 (c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED  
4 FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

5 (1) IN GENERAL.—Paragraph (2) of section  
6 220(b) of such Code is amended to read as follows:

7 “(2) MONTHLY LIMITATION.—The monthly lim-  
8 itation for any month is the amount equal to  $\frac{1}{12}$  of  
9 the annual deductible (as of the first day of such  
10 month) of the taxpayer’s coverage under the high  
11 deductible health plan.”

12 (2) CONFORMING AMENDMENT.—Clause (ii) of  
13 section 220(d)(1)(A) of such Code is amended by  
14 striking “75 percent of”.

15 (d) BOTH EMPLOYERS AND EMPLOYEES MAY CON-  
16 TRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph  
17 (5) of section 220(b) of such Code is amended to read  
18 as follows:

19 “(5) COORDINATION WITH EXCLUSION FOR EM-  
20 PLOYER CONTRIBUTIONS.—The limitation which  
21 would (but for this paragraph) apply under this sub-  
22 section to the taxpayer for any taxable year shall be  
23 reduced (but not below zero) by the amount which  
24 would (but for section 106(b)) be includible in the  
25 taxpayer’s gross income for such taxable year.”

1       (e) REDUCTION OF PERMITTED DEDUCTIBLES  
2 UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

3           (1) IN GENERAL.—Subparagraph (A) of section  
4       220(c)(2) of such Code (defining high deductible  
5       health plan) is amended—

6           (A) by striking “\$1,500” and inserting  
7       “\$1,000”, and

8           (B) by striking “\$3,000” and inserting  
9       “\$2,000”.

10          (2) CONFORMING AMENDMENT.—Subsection (g)  
11       of section 220 of such Code is amended—

12          (A) by striking “1998” and inserting  
13       “1999”, and

14          (B) by striking “1997” and inserting  
15       “1998”.

16       (f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED  
17 UNDER CAFETERIA PLANS.—Subsection (f) of section  
18 125 of such Code is amended by striking “106(b),”.

19       (g) INDIVIDUALS RECEIVING IMMEDIATE FEDERAL  
20 ANNUITIES ELIGIBLE FOR MEDICAL SAVINGS AC-  
21 COUNTS.—Paragraph (1) of section 220(c) of such Code  
22 (defining eligible individual), as amended by subsections  
23 (a) and (b), is amended by adding at the end the following  
24 new subparagraph:

1                   “(C) SPECIAL RULES FOR INDIVIDUALS  
2 RECEIVING IMMEDIATE FEDERAL ANNUITIES.—

3                   “(i) IN GENERAL.—Subparagraph  
4 (A)(iii) and subsection (b)(4) shall not  
5 apply for any month to an individual—

6                   “(I) who, as of the 1st day of  
7 such month, is enrolled in a high de-  
8 ductible health plan under chapter 89  
9 of title 5, United States Code, and

10                  “(II) who is entitled to receive  
11 for such month any amount by reason  
12 of being an annuitant (as defined in  
13 section 8901(3) of such title 5).

14                  “(ii) SPECIAL RULE FOR SPOUSE OF  
15 ANNUITANT.—In the case of the spouse of  
16 an individual described in clause (i) who is  
17 not also described in clause (i), subsection  
18 (b)(4) shall not apply to such spouse if  
19 such individual and spouse have family  
20 coverage under the same plan described in  
21 clause (i)(I).”

22                  (h) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply to taxable years ending after the  
24 date of the enactment of this Act.

1 **SEC. 3202. EXCEPTION FROM INSURANCE LIMITATION IN**  
2 **CASE OF MEDICAL SAVINGS ACCOUNTS.**

3 (a) IN GENERAL.—Section 220(d)(2)(B) of the Inter-  
4 nal Revenue Code of 1986 is amended by adding at the  
5 end the following new clause:

6 “(iii) INSURANCE OFFERED BY COM-  
7 MUNITY HEALTH CENTERS.—

8 “(I) IN GENERAL.—Subject to  
9 clauses (II) and (III), clause (i) shall  
10 not apply to any expense for coverage  
11 under insurance offered by a health  
12 center (as defined in section 330(a)(1)  
13 of the Public Health Service Act) if  
14 the coverage consists solely of cov-  
15 erage for required primary health ben-  
16 efits (as defined in section  
17 330(b)(1)(A) of such Act) provided on  
18 a capitated basis.

19 “(II) INCOME LIMITATION.—Sub-  
20 clause (I) shall only apply to expenses  
21 for coverage of an individual who, in  
22 the taxable year involved, has income  
23 that is less than 200 percent of the  
24 income official poverty line (as defined  
25 by the Office of Management and  
26 Budget, and revised annually in ac-

1 cordance with section 673(2) of the  
 2 Omnibus Budget Reconciliation Act of  
 3 1981) applicable to a family of the  
 4 size involved.

5 “(III) LIMITATION ON NUMBER  
 6 OF CONTRACTS.—For a taxable year  
 7 ending in a calendar year, subclause  
 8 (I) shall apply only to expenses for  
 9 coverage for the first 15,000 individ-  
 10 uals enrolled in insurance described in  
 11 such subclause in the year.”.

12 (b) REPORTS ON ENROLLMENT.—Section 330(j)(3)  
 13 of the Public Health Service Act (42 U.S.C. 254c(j)(3))  
 14 is amended—

15 (1) by striking “and” at the end of subpara-  
 16 graph (K),

17 (2) by striking the period at the end of sub-  
 18 paragraph (L) and inserting “; and”, and

19 (3) by inserting after subparagraph (L) the fol-  
 20 lowing new subparagraph:

21 “(M) if the center offers insurance cov-  
 22 erage to an individual with a medical savings  
 23 account under subclause (I) of section  
 24 220(d)(2)(B)(iii), the center shall provide such  
 25 reports in such time and manner as may be re-



1           quired by the Secretary and the Secretary of  
2           the Treasury in order to carry out subclause  
3           (III) of such section.”.

4           **TITLE IV—HEALTH CARE**  
5           **LAWSUIT REFORM**  
6           **Subtitle A—General Provisions**

7   **SEC. 4001. FEDERAL REFORM OF HEALTH CARE LIABILITY**  
8           **ACTIONS.**

9           (a) **APPLICABILITY.**—This title shall apply with re-  
10          spect to any health care liability action brought in any  
11          State or Federal court, except that this title shall not  
12          apply to—

13               (1) an action for damages arising from a vac-  
14          cine-related injury or death to the extent that title  
15          XXI of the Public Health Service Act applies to the  
16          action, or

17               (2) an action under the Employee Retirement  
18          Income Security Act of 1974 (29 U.S.C. 1001 et  
19          seq.).

20          (b) **PREEMPTION.**—This title shall preempt any State  
21          law to the extent such law is inconsistent with the limita-  
22          tions contained in this title. This title shall not preempt  
23          any State law that provides for defenses or places limita-  
24          tions on a person’s liability in addition to those contained

1 in this title or otherwise imposes greater restrictions than  
2 those provided in this title.

3 (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE  
4 OF LAW OR VENUE.—Nothing in subsection (b) shall be  
5 construed to—

6 (1) waive or affect any defense of sovereign im-  
7 munity asserted by any State under any provision of  
8 law;

9 (2) waive or affect any defense of sovereign im-  
10 munity asserted by the United States;

11 (3) affect the applicability of any provision of  
12 the Foreign Sovereign Immunities Act of 1976;

13 (4) preempt State choice-of-law rules with re-  
14 spect to claims brought by a foreign nation or a citi-  
15 zen of a foreign nation; or

16 (5) affect the right of any court to transfer  
17 venue or to apply the law of a foreign nation or to  
18 dismiss a claim of a foreign nation or of a citizen  
19 of a foreign nation on the ground of inconvenient  
20 forum.

21 (d) AMOUNT IN CONTROVERSY.—In an action to  
22 which this title applies and which is brought under section  
23 1332 of title 28, United States Code, the amount of non-  
24 economic damages or punitive damages, and attorneys'  
25 fees or costs, shall not be included in determining whether

1 the matter in controversy exceeds the sum or value of  
2 \$50,000.

3 (e) FEDERAL COURT JURISDICTION NOT ESTAB-  
4 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in  
5 this title shall be construed to establish any jurisdiction  
6 in the district courts of the United States over health care  
7 liability actions on the basis of section 1331 or 1337 of  
8 title 28, United States Code.

9 **SEC. 4002. DEFINITIONS.**

10 As used in this title:

11 (1) ACTUAL DAMAGES.—The term “actual dam-  
12 ages” means damages awarded to pay for economic  
13 loss.

14 (2) ALTERNATIVE DISPUTE RESOLUTION SYS-  
15 TEM; ADR.—The term “alternative dispute resolution  
16 system” or “ADR” means a system established  
17 under Federal or State law that provides for the res-  
18 olution of health care liability claims in a manner  
19 other than through health care liability actions.

20 (3) CLAIMANT.—The term “claimant” means  
21 any person who brings a health care liability action  
22 and any person on whose behalf such an action is  
23 brought. If such action is brought through or on be-  
24 half of an estate, the term includes the claimant’s  
25 decedent. If such action is brought through or on be-

1 half of a minor or incompetent, the term includes  
2 the claimant's legal guardian.

3 (4) CLEAR AND CONVINCING EVIDENCE.—The  
4 term “clear and convincing evidence” is that meas-  
5 ure or degree of proof that will produce in the mind  
6 of the trier of fact a firm belief or conviction as to  
7 the truth of the allegations sought to be established.  
8 Such measure or degree of proof is more than that  
9 required under preponderance of the evidence but  
10 less than that required for proof beyond a reason-  
11 able doubt.

12 (5) COLLATERAL SOURCE PAYMENTS.—The  
13 term “collateral source payments” means any  
14 amount paid or reasonably likely to be paid in the  
15 future to or on behalf of a claimant, or any service,  
16 product, or other benefit provided or reasonably like-  
17 ly to be provided in the future to or on behalf of a  
18 claimant, as a result of an injury or wrongful death,  
19 pursuant to—

20 (A) any State or Federal health, sickness,  
21 income-disability, accident or workers' com-  
22 pensation Act;

23 (B) any health, sickness, income-disability,  
24 or accident insurance that provides health bene-  
25 fits or income-disability coverage;

1           (C) any contract or agreement of any  
2           group, organization, partnership, or corporation  
3           to provide, pay for, or reimburse the cost of  
4           medical, hospital, dental, or income disability  
5           benefits; and

6           (D) any other publicly or privately funded  
7           program.

8           (6) DRUG.—The term “drug” has the meaning  
9           given such term in section 201(g)(1) of the Federal  
10          Food, Drug, and Cosmetic Act (21 U.S.C.  
11          321(g)(1)).

12          (7) ECONOMIC LOSS.—The term “economic  
13          loss” means any pecuniary loss resulting from injury  
14          (including the loss of earnings or other benefits re-  
15          lated to employment, medical expense loss, replace-  
16          ment services loss, loss due to death, burial costs,  
17          and loss of business or employment opportunities),  
18          to the extent recovery for such loss is allowed under  
19          applicable State law.

20          (8) HARM.—The term “harm” means any le-  
21          gally cognizable wrong or injury for which punitive  
22          damages may be imposed.

23          (9) HEALTH BENEFIT PLAN.—The term  
24          “health benefit plan” means—

1 (A) a hospital or medical expense incurred  
2 policy or certificate,

3 (B) a hospital or medical service plan con-  
4 tract,

5 (C) a health maintenance subscriber con-  
6 tract, or

7 (D) a Medicare+Choice plan (offered  
8 under part C of title XVIII of the Social Secu-  
9 rity Act),  
10 that provides benefits with respect to health care  
11 services.

12 (10) HEALTH CARE LIABILITY ACTION.—The  
13 term “health care liability action” means a civil ac-  
14 tion brought in a State or Federal court against—

15 (A) a health care provider,

16 (B) an entity which is obligated to provide  
17 or pay for health benefits under any health ben-  
18 efit plan (including any person or entity acting  
19 under a contract or arrangement to provide or  
20 administer any health benefit), or

21 (C) the manufacturer, distributor, supplier,  
22 marketer, promoter, or seller of a medical prod-  
23 uct,

24 in which the claimant alleges a claim (including third  
25 party claims, cross claims, counter claims, or contribution

1 claims) based upon the provision of (or the failure to pro-  
2 vide or pay for) health care services or the use of a medical  
3 product, regardless of the theory of liability on which the  
4 claim is based or the number of plaintiffs, defendants, or  
5 causes of action.

6 (11) HEALTH CARE LIABILITY CLAIM.—The  
7 term “health care liability claim” means a claim in  
8 which the claimant alleges that injury was caused by  
9 the provision of (or the failure to provide) health  
10 care services.

11 (12) HEALTH CARE PROVIDER.—The term  
12 “health care provider” means any person that is en-  
13 gaged in the delivery of health care services in a  
14 State and that is required by the laws or regulations  
15 of the State to be licensed or certified by the State  
16 to engage in the delivery of such services in the  
17 State.

18 (13) HEALTH CARE SERVICE.—The term  
19 “health care service” means any service eligible for  
20 payment under a health benefit plan, including serv-  
21 ices related to the delivery or administration of such  
22 service.

23 (14) MEDICAL DEVICE.—The term “medical de-  
24 vice” has the meaning given such term in section

1       201(h) of the Federal Food, Drug, and Cosmetic  
2       Act (21 U.S.C. 321(h)).

3           (15) NON-ECONOMIC DAMAGES.—The term  
4       “non-economic damages” means damages paid to an  
5       individual for pain and suffering, inconvenience,  
6       emotional distress, mental anguish, loss of consor-  
7       tium, injury to reputation, humiliation, and other  
8       nonpecuniary losses.

9           (16) PERSON.—The term “person” means any  
10      individual, corporation, company, association, firm,  
11      partnership, society, joint stock company, or any  
12      other entity, including any governmental entity.

13          (17) PRODUCT SELLER.—

14           (A) IN GENERAL.—Subject to subpara-  
15      graph (B), the term “product seller” means a  
16      person who, in the course of a business con-  
17      ducted for that purpose—

18                  (i) sells, distributes, rents, leases, pre-  
19                  pares, blends, packages, labels, or is other-  
20                  wise involved in placing, a product in the  
21                  stream of commerce, or

22                  (ii) installs, repairs, or maintains the  
23                  harm-causing aspect of a product.

24           (B) EXCLUSION.—Such term does not in-  
25      clude—



1 (i) a seller or lessor of real property;

2 (ii) a provider of professional services

3 in any case in which the sale or use of a

4 product is incidental to the transaction and

5 the essence of the transaction is the fur-

6 nishing of judgment, skill, or services; or

7 (iii) any person who—

8 (I) acts in only a financial capac-

9 ity with respect to the sale of a prod-

10 uct; or

11 (II) leases a product under a

12 lease arrangement in which the selec-

13 tion, possession, maintenance, and op-

14 eration of the product are controlled

15 by a person other than the lessor.

16 (18) PUNITIVE DAMAGES.—The term “punitive

17 damages” means damages awarded against any per-

18 son not to compensate for actual injury suffered, but

19 to punish or deter such person or others from en-

20 gaging in similar behavior in the future.

21 (19) STATE.—The term “State” means each of

22 the several States, the District of Columbia, Puerto

23 Rico, the Virgin Islands, Guam, American Samoa,

24 the Northern Mariana Islands, and any other terri-

25 tory or possession of the United States.

1 **SEC. 4003. EFFECTIVE DATE.**

2 This title will apply to—

3 (1) any health care liability action brought in a  
4 Federal or State court, and

5 (2) any health care liability claim subject to an  
6 alternative dispute resolution system,

7 that is initiated on or after the date of enactment of this  
8 title, except that any health care liability claim or action  
9 arising from an injury occurring before the date of enact-  
10 ment of this title shall be governed by the applicable stat-  
11 ute of limitations provisions in effect at the time the injury  
12 occurred.

13 **Subtitle B—Uniform Standards for**  
14 **Health Care Liability Actions**

15 **SEC. 4011. STATUTE OF LIMITATIONS.**

16 A health care liability action may not be brought  
17 after the expiration of the 2-year period that begins on  
18 the date on which the alleged injury that is the subject  
19 of the action was discovered or should reasonably have  
20 been discovered, but in no case after the expiration of the  
21 5-year period that begins on the date the alleged injury  
22 occurred.

23 **SEC. 4012. CALCULATION AND PAYMENT OF DAMAGES.**

24 (a) TREATMENT OF NON-ECONOMIC DAMAGES.—

25 (1) LIMITATION ON NON-ECONOMIC DAM-  
26 AGES.—The total amount of non-economic damages

1       that may be awarded to a claimant for losses result-  
2       ing from the injury which is the subject of a health  
3       care liability action may not exceed \$250,000, re-  
4       gardless of the number of parties against whom the  
5       action is brought or the number of actions brought  
6       with respect to the injury. The limitation under this  
7       paragraph shall not apply to an action for damages  
8       based solely on intentional denial of medical treat-  
9       ment necessary to preserve a patient's life that the  
10      patient is otherwise qualified to receive, against the  
11      wishes of a patient, or if the patient is incompetent,  
12      against the wishes of the patient's guardian, on the  
13      basis of the patient's present or predicated age, dis-  
14      ability, degree of medical dependency, or quality of  
15      life.

16           (2) LIMIT.—If, after the date of the enactment  
17      of this Act, a State enacts a law which prescribes  
18      the amount of non-economic damages which may be  
19      awarded in a health care liability action which is dif-  
20      ferent from the amount prescribed by section  
21      4012(a)(1), the State amount shall apply in lieu of  
22      the amount prescribed by such section. If, after the  
23      date of the enactment of this Act, a State enacts a  
24      law which limits the amount of recovery in a health  
25      care liability action without delineating between eco-

1        nomic and non-economic damages, the State amount  
2        shall apply in lieu of the amount prescribed by such  
3        section.

4            (3) JOINT AND SEVERAL LIABILITY.—In any  
5        health care liability action brought in State or Fed-  
6        eral court, a defendant shall be liable only for the  
7        amount of non-economic damages attributable to  
8        such defendant in direct proportion to such defend-  
9        ant's share of fault or responsibility for the claim-  
10      ant's actual damages, as determined by the trier of  
11      fact. In all such cases, the liability of a defendant  
12      for non-economic damages shall be several and not  
13      joint and a separate judgment shall be rendered  
14      against each defendant for the amount allocated to  
15      such defendant.

16      (b) TREATMENT OF PUNITIVE DAMAGES.—

17            (1) GENERAL RULE.—Punitive damages may,  
18      to the extent permitted by applicable State law, be  
19      awarded in any health care liability action for harm  
20      in any Federal or State court against a defendant if  
21      the claimant establishes by clear and convincing evi-  
22      dence that the harm suffered was the result of con-  
23      duct—

24            (A) specifically intended to cause harm, or

1 (B) conduct manifesting a conscious, fla-  
2 grant indifference to the rights or safety of oth-  
3 ers.

4 (2) APPLICABILITY.—This subsection shall  
5 apply to any health care liability action brought in  
6 any Federal or State court on any theory where pu-  
7 nitive damages are sought. This subsection does not  
8 create a cause of action for punitive damages. This  
9 subsection does not preempt or supersede any State  
10 or Federal law to the extent that such law would  
11 further limit the award of punitive damages.

12 (3) BIFURCATION.—At the request of any  
13 party, the trier of fact shall consider in a separate  
14 proceeding whether punitive damages are to be  
15 awarded and the amount of such award. If a sepa-  
16 rate proceeding is requested, evidence relevant only  
17 to the claim of punitive damages, as determined by  
18 applicable State law, shall be inadmissible in any  
19 proceeding to determine whether actual damages are  
20 to be awarded.

21 (4) DRUGS AND DEVICES.—

22 (A) IN GENERAL.—

23 (i) PUNITIVE DAMAGES.—Punitive  
24 damages shall not be awarded against a  
25 manufacturer or product seller of a drug

1 or medical device which caused the claim-  
2 ant's harm where—

3 (I) such drug or device was sub-  
4 ject to premarket approval by the  
5 Food and Drug Administration with  
6 respect to the safety of the formula-  
7 tion or performance of the aspect of  
8 such drug or device which caused the  
9 claimant's harm, or the adequacy of  
10 the packaging or labeling of such drug  
11 or device which caused the harm, and  
12 such drug, device, packaging, or label-  
13 ing was approved by the Food and  
14 Drug Administration; or

15 (II) the drug is generally recog-  
16 nized as safe and effective pursuant to  
17 conditions established by the Food  
18 and Drug Administration and applica-  
19 ble regulations, including packaging  
20 and labeling regulations.

21 (ii) APPLICATION.—Clause (i) shall  
22 not apply in any case in which the defend-  
23 ant, before or after premarket approval of  
24 a drug or device—

1 (I) intentionally and wrongfully  
2 withheld from or misrepresented to  
3 the Food and Drug Administration in-  
4 formation concerning such drug or de-  
5 vice required to be submitted under  
6 the Federal Food, Drug, and Cos-  
7 metic Act (21 U.S.C. 301 et seq.) or  
8 section 351 of the Public Health Serv-  
9 ice Act (42 U.S.C. 262) that is mate-  
10 rial and relevant to the harm suffered  
11 by the claimant, or

12 (II) made an illegal payment to  
13 an official or employee of the Food  
14 and Drug Administration for the pur-  
15 pose of securing or maintaining ap-  
16 proval of such drug or device.

17 (B) PACKAGING.—In a health care liability  
18 action for harm which is alleged to relate to the  
19 adequacy of the packaging or labeling of a drug  
20 which is required to have tamper-resistant  
21 packaging under regulations of the Secretary of  
22 Health and Human Services (including labeling  
23 regulations related to such packaging), the  
24 manufacturer or product seller of the drug shall  
25 not be held liable for punitive damages unless

1           such packaging or labeling is found by the court  
2           by clear and convincing evidence to be substan-  
3           tially out of compliance with such regulations.

4       (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

5           (1) GENERAL RULE.—In any health care liabil-  
6       ity action in which the damages awarded for future  
7       economic and non-economic loss exceeds \$50,000, a  
8       person shall not be required to pay such damages in  
9       a single, lump-sum payment, but shall be permitted  
10      to make such payments periodically based on when  
11      the damages are likely to occur, as such payments  
12      are determined by the court.

13          (2) FINALITY OF JUDGMENT.—The judgment  
14      of the court awarding periodic payments under this  
15      subsection may not, in the absence of fraud, be re-  
16      opened at any time to contest, amend, or modify the  
17      schedule or amount of the payments.

18          (3) LUMP-SUM SETTLEMENTS.—This sub-  
19      section shall not be construed to preclude a settle-  
20      ment providing for a single, lump-sum payment.

21      (d) TREATMENT OF COLLATERAL SOURCE PAY-  
22      MENTS.—

23          (1) INTRODUCTION INTO EVIDENCE.—In any  
24      health care liability action, any defendant may intro-  
25      duce evidence of collateral source payments. If any



1       defendant elects to introduce such evidence, the  
2       claimant may introduce evidence of any amount paid  
3       or contributed or reasonably likely to be paid or con-  
4       tributed in the future by or on behalf of the claim-  
5       ant to secure the right to such collateral source pay-  
6       ments.

7           (2) NO SUBROGATION.—No provider of collat-  
8       eral source payments shall recover any amount  
9       against the claimant or receive any lien or credit  
10      against the claimant's recovery or be equitably or le-  
11      gally subrogated to the right of the claimant in a  
12      health care liability action.

13          (3) APPLICATION TO SETTLEMENTS.—This sub-  
14      section shall apply to an action that is settled as well  
15      as an action that is resolved by a fact finder.

16   **SEC. 4013. ALTERNATIVE DISPUTE RESOLUTION.**

17      Any ADR used to resolve a health care liability action  
18      or claim shall contain provisions relating to statute of limi-  
19      tations, non-economic damages, joint and several liability,  
20      punitive damages, collateral source rule, and periodic pay-  
21      ments which are consistent with the provisions relating to  
22      such matters in this title.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

10 “INSPECTION AND COPYING OF PROTECTED HEALTH  
11 INFORMATION

22 “(b) ACCESS THROUGH ORIGINATING PROVIDER.—  
23 Protected health information that is created by an origi-  
24 nating provider, and subsequently received by another  
25 health care provider or a health plan as part of treatment

1 or payment activities, shall be made available for inspec-  
2 tion and copying as provided in this section through the  
3 originating provider, rather than the receiving health care  
4 provider or health plan, unless the originating provider  
5 does not maintain the information.

6 “(c) INVESTIGATIONAL INFORMATION.—With respect  
7 to protected health information that was created as part  
8 of the requesting individual’s participation in a clinical  
9 trial monitored by an institutional review board estab-  
10 lished to review health research with respect to potential  
11 risks to human subjects pursuant to Federal regulations  
12 adopted under section 1802(b) of the Public Health Serv-  
13 ice Act (42 U.S.C. 300v–1(b)) and the notice (informally  
14 referred to as the ‘Common Rule’) promulgated in the  
15 Federal Register at 56 Fed. Reg. 28003), a request under  
16 subsection (a) shall be granted only to the extent and in  
17 a manner consistent with such regulations.

18 “(d) OTHER EXCEPTIONS.—Unless ordered by a  
19 court of competent jurisdiction, a person to whom a re-  
20 quest under subsection (a) is made is not required to grant  
21 the request, if—

22 “(1) the person determines that the disclosure  
23 of the information could reasonably be expected to  
24 endanger the life or physical safety of, or cause sub-  
25 stantial harm to, any individual; or

1           “(2) the information is compiled principally—

2                   “(A) in anticipation of a civil, criminal, or  
3           administrative action or proceeding; or

4                   “(B) for use in such action or proceeding.

5       “(e) DENIAL OF REQUEST FOR INSPECTION OR  
6   COPYING.—If a person to whom a request under sub-  
7   section (a) is made denies a request for inspection or copy-  
8   ing pursuant to this section, the person shall inform the  
9   individual making the request, in writing, of—

10           “(1) the reasons for the denial of the request;

11           “(2) the availability of procedures for further  
12   review of the denial; and

13           “(3) the individual’s right to file with the per-  
14   son a concise statement setting forth the request.

15       “(f) STATEMENT REGARDING REQUEST.—If an indi-  
16   vidual has filed with a person a statement under sub-  
17   section (e)(3) with respect to protected health information,  
18   the person, in any subsequent disclosure of the informa-  
19   tion—

20           “(1) shall include a notation concerning the in-  
21   dividual’s statement; and

22           “(2) may include a concise statement of the  
23   reasons for denying the request for inspection or  
24   copying.

1       “(g) PROCEDURES.—A person providing access to  
2 protected health information for inspection or copying  
3 under this section may set forth appropriate procedures  
4 to be followed for such inspection or copying and may re-  
5 quire an individual to pay reasonable costs associated with  
6 such inspection or copying.

7       “(h) INSPECTION AND COPYING OF SEGREGABLE  
8 PORTION.—A person to whom a request under subsection  
9 (a) is made shall permit the inspection and copying of any  
10 reasonably segregable portion of a record after deletion of  
11 any portion that the person is not required to disclose  
12 under this section.

13       “(i) DEADLINE.—A person described in subsection  
14 (a) shall comply with or deny, in accordance with this sec-  
15 tion, a request for inspection or copying of protected  
16 health information under this section not later than 30  
17 days after the date on which the person receives the re-  
18 quest.

19       “(j) RULES GOVERNING AGENTS.—An agent of a  
20 person described in subsection (a) shall not be required  
21 to provide for the inspection and copying of protected  
22 health information, except where—

23               “(1) the protected health information is re-  
24       tained by the agent; and

3 “SUPPLEMENTATION OF PROTECTED HEALTH  
4 INFORMATION

5           “SEC. 1182. (a) IN GENERAL.—Subject to subsection  
6   (b), not later than 45 days after the date on which a per-  
7   son who is a health care provider, health plan, employer,  
8   health or life insurer, or educational institution receives,  
9   from an individual who is a subject of protected health  
10   information that is maintained by the person, a request  
11   in writing to amend the information by adding a concise  
12   written supplement to it, the person—

13                   “(1) shall make the amendment requested;

14                   “(2) shall inform the individual of the amend-  
15                   ment that has been made; and

“(3) shall make reasonable efforts to inform any person who is identified by the individual, who is not an officer, employer, or agent of the person receiving the request, and to whom the unamended portion of the information was disclosed during the preceding year, by sending a notice to the person’s last known address that an amendment, consisting of the addition of a supplement, has been made to the protected health information of the individual.

25       “(b) REFUSAL TO AMEND.—If a person described in  
26 subsection (a) refuses to make an amendment requested

1 by an individual under such subsection, the person shall  
2 inform the individual, in writing, of—

3 “(1) the reasons for the refusal to make the  
4 amendment;

5 “(2) any procedures for further review of the  
6 refusal; and

7 “(3) the individual’s right to file with the per-  
8 son a concise statement setting forth the requested  
9 amendment and the individual’s reasons for dis-  
10 agreeing with the refusal.

11 “(c) STATEMENT OF DISAGREEMENT.—If an individ-  
12 ual has filed a statement of disagreement with a person  
13 under subsection (b)(3), the person, in any subsequent dis-  
14 closure of the disputed portion of the information—

15 “(1) shall include a notation that such individ-  
16 ual has filed a statement of disagreement; and

17 “(2) may include a concise statement of the  
18 reasons for not making the requested amendment.

19 “(d) RULES GOVERNING AGENTS.—The agent of a  
20 person described in subsection (a) shall not be required  
21 to make amendments to individually identifiable health in-  
22 formation, except where—

23 “(1) the information is retained by the agent;  
24 and

1           “(2) the agent has been asked by such person  
2           to fulfill the requirements of this section.

3           “(e) DUPLICATIVE REQUESTS FOR AMENDMENTS.—  
4           If a person described in subsection (a) receives a duplica-  
5           tive request for an amendment of information as provided  
6           for in such subsection and a statement of disagreement  
7           with respect to the request has been filed pursuant to sub-  
8           section (c), the person shall inform the individual of such  
9           filing and shall not be required to carry out the procedures  
10          under this section.

11          “(f) RULE OF CONSTRUCTION.—This section shall  
12          not be construed—

13                 “(1) to permit an individual to modify state-  
14                 ments in his or her record that document the factual  
15                 observations of another individual or state the re-  
16                 sults of diagnostic tests; or

17                 “(2) to permit an individual to amend his or  
18                 her record as to the type, duration, or quality of  
19                 treatment the individual believes he or she should  
20                 have been provided.

21           “NOTICE OF CONFIDENTIALITY PRACTICES

22           “SEC. 1183. (a) PREPARATION OF WRITTEN NO-  
23           TICE.—A person who is a health care provider, health  
24           plan, health oversight agency, public health authority, em-  
25           ployer, health or life insurer, health researcher, or edu-  
26           cational institution shall post or provide, in writing and



1 in a clear and conspicuous manner, notice of the person's  
2 protected health information confidentiality practices. The  
3 notice shall include—

4 “(1) a description of an individual's rights with  
5 respect to protected health information;

6 “(2) the intended uses and disclosures of pro-  
7 tected health information;

8 “(3) the procedures established by the person  
9 for the exercise of an individual's rights with respect  
10 to protected health information; and

11 “(4) the procedures established by the person  
12 for obtaining copies of the notice.

13 “(b) MODEL NOTICE.—The Secretary, after notice  
14 and opportunity for public comment, and based on the ad-  
15 vice of the National Committee on Vital and Health Sta-  
16 tistics established under section 306(k) of the Public  
17 Health Service Act (42 U.S.C. 242k(k)), shall develop and  
18 disseminate, not later than 6 months after the date of the  
19 enactment of the Patient Protection Act of 1998, model  
20 notices of confidentiality practices, for use under this sec-  
21 tion. Use of a model notice developed by the Secretary  
22 shall serve as a complete defense in any civil action to an  
23 allegation that a violation of this section has occurred.

24 “ESTABLISHMENT OF SAFEGUARDS

25 “SEC. 1184. (a) IN GENERAL.—A person who is a  
26 health care provider, health plan, health oversight agency,

1 public health authority, employer, health or life insurer,  
2 health researcher, or educational institution shall estab-  
3 lish, maintain, and enforce reasonable and appropriate ad-  
4 ministrative, technical, and physical safeguards to protect  
5 the confidentiality, security, accuracy, and integrity of  
6 protected health information created, received, obtained,  
7 maintained, used, transmitted, or disposed of by the per-  
8 son.

9 “(b) FACTORS TO BE CONSIDERED.—A person sub-  
10 ject to subsection (a) shall consider the following factors  
11 in establishing safeguards under such subsection:

12 “(1) The need for protected health information.

13 “(2) The categories of personnel who will have  
14 access to protected health information.

15 “(3) The feasibility of limiting access to individ-  
16 ual identifiers.

17 “(4) The appropriateness of the policy or proce-  
18 dure to the person, and to the medium in which pro-  
19 tected health information is stored and transmitted.

20 “(5) The value of audit trails in computerized  
21 records.

22 “(c) RELATIONSHIP TO PART C REQUIREMENT.—  
23 Any safeguard established under this section shall be con-  
24 sistent with the requirement in section 1173(d)(2).

1       “(d) CONVERSION TO NONIDENTIFIABLE HEALTH  
2 INFORMATION.—A person subject to subsection (a) shall,  
3 to the extent practicable and consistent with the purpose  
4 for which protected health information is maintained, con-  
5 vert such information into nonidentifiable health informa-  
6 tion.

7       “AVAILABILITY OF PROTECTED HEALTH INFORMATION  
8       FOR PURPOSES OF HEALTH CARE OPERATIONS

9       “SEC. 1185. DISCLOSURE.—Any person who main-  
10 tains protected health information may disclose the infor-  
11 mation to a health care provider or a health plan for the  
12 purpose of permitting the provider or plan to conduct  
13 health care operations.

14       “(b) USE.—A health care provider or a health plan  
15 that maintains protected health information may use it for  
16 the purposes described in subsection (a).

17       “RELATIONSHIP TO OTHER LAWS

18       “SEC. 1186. (a) STATE LAW.—

19       “(1) IN GENERAL.—Except as provided in para-  
20 graphs (2) and (3), the provisions of this part shall  
21 preempt a provision of State law to the extent that  
22 such provision—

23       “(A) otherwise would be preempted as in-  
24 consistent with this part under article VI of the  
25 Constitution of the United States;

1           “(B) relates to authorization for the use or  
2 disclosure of—

3           “(i) protected health information for  
4 health care operations; or

5           “(ii) nonidentifiable health informa-  
6 tion; or

7           “(C) relates to any of the following:

8           “(i) Inspection or copying of protected  
9 health information by a person who is a  
10 subject of the information.

11           “(ii) Amendment of protected health  
12 information by a person who is a subject  
13 of the information.

14           “(iii) Notice of confidentiality prac-  
15 tices with respect to protected health infor-  
16 mation.

17           “(iv) Establishment of safeguards for  
18 protected health information.

19           “(2) EXCEPTIONS.—Nothing in this part shall  
20 be construed to preempt or modify a provision of  
21 State law to the extent that such provision relates  
22 to protected health information and—

23           “(A) the confidentiality of the records  
24 maintained by a licensed mental health profes-  
25 sional;

1           “(B) the provision of health care to a  
2           minor, or the disclosure of information about a  
3           minor to a parent or guardian of the minor;

4           “(C) condition-specific limitations on dis-  
5           closure;

6           “(D) the use or disclosure of information  
7           for use in legally authorized—

8                   “(i) disease or injury reporting;

9                   “(ii) public health surveillance, inves-  
10                  tigation, or intervention;

11                  “(iii) vital statistics reporting, such as  
12                  reporting of birth or death information;

13                  “(iv) reporting of abuse or neglect in-  
14                  formation;

15                  “(v) reporting of information concern-  
16                  ing a communicable disease status; or

17                  “(vi) reporting concerning the safety  
18                  or effectiveness of a biological product reg-  
19                  ulated under section 351 of the Public  
20                  Health Service Act (42 U.S.C. 262) or a  
21                  drug or device regulated under the Federal  
22                  Food, Drug, and Cosmetic Act (21 U.S.C.  
23                  301 et seq.);

24           “(E) the disclosure to a person by a health  
25           care provider of information about an individ-

1 ual, in any case in which the provider has de-  
2 termined—

3 “(i) in the provider’s reasonable medi-  
4 cal judgment, that the individual is uncon-  
5 scious, incompetent, or otherwise incapable  
6 of deciding whether to authorize disclosure  
7 of the protected health information; and

8 “(ii) in the provider’s reasonable judg-  
9 ment, that the person is a spouse, relative,  
10 guardian, or close friend of the individ-  
11 ual’s; or

12 “(F) the use of information by, or the dis-  
13 closure of information to, a person holding a  
14 valid and applicable power of attorney that in-  
15 cludes the authority to make health care deci-  
16 sions on behalf of an individual who is a subject  
17 of the information.

18 “(3) PRIVILEGES.—Nothing in this part shall  
19 be construed to preempt or modify a provision of  
20 State law to the extent that such provision relates  
21 to a privilege of a witness or other person in a court  
22 of that State.

23 “(b) FEDERAL LAW.—Nothing in this part shall be  
24 construed to preempt, modify, or repeal a provision of any  
25 other Federal law relating to protected health information

1 or relating to an individual's access to protected health  
2 information or health care services. Nothing in this part  
3 shall be construed to preempt, modify, or repeal a provi-  
4 sion of Federal law to the extent that such provision re-  
5 lates to a privilege of a witness or other person in a court  
6 of the United States.

7 "CIVIL PENALTIES

8 "SEC. 1187. (a) VIOLATION.—A person who the Sec-  
9 retary determines has substantially and materially failed  
10 to comply with this part shall be subject, in addition to  
11 any other penalties that may be prescribed by law—

12 "(1) in a case in which the violation relates to  
13 section 1181 or 1182, to a civil penalty of not more  
14 than \$500 for each such violation but not to exceed  
15 \$5,000 in the aggregate for all violations of an iden-  
16 tical requirement or prohibition during a calendar  
17 year;

18 "(2) in the case in which the violation relates  
19 to section 1183 or 1184, to a civil penalty of not  
20 more than \$10,000 for each such violation, but not  
21 to exceed \$50,000 in the aggregate for all violations  
22 of an identical requirement or prohibition during a  
23 calendar year; or

24 "(3) in a case in which the Secretary finds that  
25 such violations have occurred with such frequency as

1 to constitute a general business practice, to a civil  
2 penalty of not more than \$100,000.

3 “(b) PROCEDURES FOR IMPOSITION OF PEN-  
4 ALTIES.—Section 1128A, other than subsections (a) and  
5 (b) and the second sentence of subsection (f) of that sec-  
6 tion, shall apply to the imposition of a civil or monetary  
7 penalty under this section in the same manner as such  
8 provisions apply with respect to the imposition of a penalty  
9 under section 1128A.

10 “DEFINITIONS

11 “SEC. 1188. As used in this part:

12 “(1) AGENT.—The term ‘agent’ means a per-  
13 son, including a contractor, who represents and acts  
14 for another under the contract or relation of agency,  
15 or whose function is to bring about, modify, affect,  
16 accept performance of, or terminate contractual obli-  
17 gations between the principal and a third person.

18 “(2) CONDITION-SPECIFIC LIMITATIONS ON DIS-  
19 CLOSURE.—The term ‘condition-specific limitations  
20 on disclosure’ means State laws that prohibit the  
21 disclosure of protected health information relating to  
22 a health condition or disease that has been identified  
23 by the Secretary as posing a public health threat.

24 “(3) DISCLOSE.—The term ‘disclose’ means to  
25 release, transfer, provide access to, or otherwise di-  
26 vulge protected health information to any person



1 other than an individual who is the subject of such  
2 information.

3 “(4) EDUCATIONAL INSTITUTION.—The term  
4 ‘educational institution’ means an institution or  
5 place accredited or licensed for purposes of providing  
6 for instruction or education, including an elementary  
7 school, secondary school, or institution of higher  
8 learning, a college, or an assemblage of colleges  
9 united under one corporate organization or govern-  
10 ment.

11 “(5) EMPLOYER.—The term ‘employer’ has the  
12 meaning given such term under section 3(5) of the  
13 Employee Retirement Income Security Act of 1974  
14 (29 U.S.C. 1002(5)), except that such term shall in-  
15 clude only employers of two or more employees.

16 “(6) HEALTH CARE.—The term ‘health care’  
17 means—

18 “(A) preventive, diagnostic, therapeutic,  
19 rehabilitative, maintenance, or palliative care,  
20 including appropriate assistance with disease or  
21 symptom management and maintenance, coun-  
22 seling, service, or procedure—

23 “(i) with respect to the physical or  
24 mental condition of an individual; or

1                   “(ii) affecting the structure or func-  
2                   tion of the human body or any part of the  
3                   human body, including the banking of  
4                   blood, sperm, organs, or any other tissue;  
5                   or

6                   “(B) any sale or dispensing, pursuant to a  
7                   prescription or medical order, of a drug, device,  
8                   equipment, or other health care-related item to  
9                   an individual, or for the use of an individual.

10                  “(7) HEALTH CARE OPERATIONS.—The term  
11                  ‘health care operations’ means services, provided di-  
12                  rectly by or on behalf of a health plan or health care  
13                  provider or by its agent, for any of the following  
14                  purposes:

15                       “(A) Coordinating health care, including  
16                       health care management of the individual  
17                       through risk assessment, case management, and  
18                       disease management.

19                       “(B) Conducting quality assessment and  
20                       improvement activities, including outcomes eval-  
21                       uation, clinical guideline development and im-  
22                       provement, and health promotion.

23                       “(C) Carrying out utilization review activi-  
24                       ties, including precertification and  
25                       preauthorization of services, and health plan

1 rating activities, including underwriting and ex-  
2 perience rating.

3 “(D) Conducting or arranging for auditing  
4 services.

5 “(8) HEALTH CARE PROVIDER.—The term  
6 ‘health care provider’ means a person, who with re-  
7 spect to a specific item of protected health informa-  
8 tion, receives, creates, uses, maintains, or discloses  
9 the information while acting in whole or in part in  
10 the capacity of—

11 “(A) a person who is licensed, certified,  
12 registered, or otherwise authorized by Federal  
13 or State law to provide an item or service that  
14 constitutes health care in the ordinary course of  
15 business, or practice of a profession;

16 “(B) a Federal, State, or employer-spon-  
17 sored or any other privately-sponsored program  
18 that directly provides items or services that con-  
19 stitute health care to beneficiaries; or

20 “(C) an officer or employee of a person de-  
21 scribed in subparagraph (A) or (B).

22 “(9) HEALTH OR LIFE INSURER.—The term  
23 ‘health or life insurer’ means a health insurance  
24 issuer, as defined in section 9832(b)(2) of the Inter-

1       nal Revenue Code of 1986, or a life insurance com-  
2       pany, as defined in section 816 of such Code.

3           “(10) HEALTH PLAN.—The term ‘health plan’  
4       means any health insurance plan, including any hos-  
5       pital or medical service plan, dental or other health  
6       service plan, health maintenance organization plan,  
7       plan offered by a provider-sponsored organization  
8       (as defined in section 1855(d)), or other program  
9       providing or arranging for the provision of health  
10      benefits.

11          “(11) HEALTH RESEARCHER.—The term  
12      ‘health researcher’ means a person (or an officer,  
13      employee, or agent of a person) who is engaged in  
14      systematic investigation, including research develop-  
15      ment, testing, data analysis, and evaluation, de-  
16      signed to develop or contribute to generalizable  
17      knowledge relating to basic biomedical processes,  
18      health, health care, health care delivery, or health  
19      care cost.

20          “(12) NONIDENTIFIABLE HEALTH INFORMA-  
21      TION.—The term ‘nonidentifiable health information’  
22      means protected health information from which per-  
23      sonal identifiers that reveal the identity of the indi-  
24      vidual who is the subject of such information or pro-  
25      vide a direct means of identifying the individual

1 (such as name, address, and social security number)  
2 have been removed, encrypted, or replaced with a  
3 code, such that the identity of the individual is not  
4 evident without (in the case of encrypted or coded  
5 information) use of a key.

6 “(13) ORIGINATING PROVIDER.—The term  
7 ‘originating provider’, when used with respect to  
8 protected health information, means the health care  
9 provider who takes an action that initiates the treat-  
10 ment episode to which that information relates, such  
11 as prescribing a drug, ordering a diagnostic test, or  
12 admitting an individual to a health care facility. A  
13 hospital or nursing facility is the originating pro-  
14 vider with respect to protected health information  
15 created or received as part of inpatient or outpatient  
16 treatment provided in the hospital or facility.

17 “(14) PAYMENT ACTIVITIES.—The term ‘pay-  
18 ment activities’ means—

19 “(A) activities undertaken—

20 “(i) by, or on behalf of, a health plan  
21 to determine its responsibility for coverage  
22 under the plan; or

23 “(ii) by a health care provider to ob-  
24 tain payment for items or services provided  
25 to an individual, provided under a health

1 plan, or provided based on a determination  
2 by the health plan of responsibility for cov-  
3 erage under the plan; and

4 “(B) includes the following activities, when  
5 performed in a manner consistent with subpara-  
6 graph (A):

7 “(i) Billing, claims management, med-  
8 ical data processing, other administrative  
9 services, and actual payment.

10 “(ii) Determinations of coverage or  
11 adjudication of health benefit or subroga-  
12 tion claims.

13 “(iii) Review of health care services  
14 with respect to coverage under a health  
15 plan or justification of charges.

16 “(15) PERSON.—The term ‘person’ means—

17 “(A) a natural person;

18 “(B) a government or governmental sub-  
19 division, agency, or authority;

20 “(C) a company, corporation, estate, firm,  
21 trust, partnership, association, joint venture,  
22 society, or joint stock company; or

23 “(D) any other legal entity.

24 “(16) PROTECTED HEALTH INFORMATION.—

25 The term ‘protected health information’, when used

1 with respect to an individual who is a subject of in-  
2 formation means any information (including genetic  
3 information) that identifies the individual, whether  
4 oral or recorded in any form or medium, and that—

5 “(A) is created or received by a health care  
6 provider, health plan, health oversight agency,  
7 public health authority, employer, health or life  
8 insurer, or educational institution;

9 “(B) relates to the past, present, or future  
10 physical or mental health or condition of an in-  
11 dividual (including individual cells and their  
12 components);

13 “(C) is derived from—

14 “(i) the provision of health care to an  
15 individual; or

16 “(ii) payment for the provision of  
17 health care to an individual; and

18 “(D) is not nonidentifiable health informa-  
19 tion.

20 “(17) STATE.—The term ‘State’ includes the  
21 District of Columbia, Puerto Rico, the Virgin Is-  
22 lands, Guam, American Samoa, and the Northern  
23 Mariana Islands.

1           “(18) TREATMENT.—The term ‘treatment’  
2       means the provision of health care by a health care  
3       provider.

4           “(19) WRITING.—The term ‘writing’ means  
5       writing either in a paper-based, computer-based, or  
6       electronic form, including electronic signatures.”.

7       (b) ENFORCEMENT OF PROVISIONS THROUGH CON-  
8       DITIONS ON PARTICIPATION.—

9           (1) PARTICIPATING PHYSICIANS AND SUPPLI-  
10       ERS.—Section 1842(h) of the Social Security Act  
11       (42 U.S.C. 1395u(h)) is amended by adding at the  
12       end the following:

13       “(9) The Secretary may refuse to enter into an agree-  
14       ment with a physician or supplier under this subsection,  
15       or may terminate or refuse to renew such agreement, in  
16       the event that such physician or supplier has been found  
17       to have violated a provision of part D of title XI.”.

18           (2) MEDICARE+CHOICE ORGANIZATIONS.—Sec-  
19       tion 1852(h) of the Social Security Act (42 U.S.C.  
20       1395w-22(h)) is amended—

21           (A) in the matter preceding paragraph (1),  
22       by striking “procedures—” and inserting “pro-  
23       cedures, consistent with sections 1181 through  
24       1185—”; and



1 (B) in paragraph (1), by striking “privacy  
2 of any individually identifiable enrollee informa-  
3 tion;” and inserting “confidentiality of pro-  
4 tected health information concerning enroll-  
5 ees;”.

6 (3) MEDICARE PROVIDERS.—Section  
7 1866(a)(1) of the Social Security Act (42 U.S.C.  
8 1395cc(a)(1)) is amended—

9 (A) by inserting a semicolon at the end of  
10 subparagraph (R);

11 (B) by striking the period at the end of  
12 subparagraph (S) and inserting “; and”; and

13 (C) by inserting immediately after sub-  
14 paragraph (S) the following new subparagraph:

15 “(T) to comply with sections 1181 through  
16 1184.”.

17 (4) HEALTH MAINTENANCE ORGANIZATIONS  
18 WITH RISK-SHARING CONTRACTS.—Section  
19 1876(k)(4) of the Social Security Act (42 U.S.C.  
20 1395mm(k)(4)) of the Social Security Act is amend-  
21 ed by adding at the end the following:

22 “(E) The confidentiality and accuracy proce-  
23 dure requirements under section 1852(h).”.

24 (c) CONFORMING AMENDMENTS.—

1           (1) TITLE HEADING.—Title XI of the Social  
2       Security Act (42 U.S.C. 1301 et seq.) is amended by  
3       striking the title heading and inserting the following:  
4       “TITLE XI—GENERAL PROVISIONS, PEER RE-  
5       VIEW, ADMINISTRATIVE SIMPLIFICATION,  
6       AND CONFIDENTIALITY OF PROTECTED  
7       HEALTH INFORMATION”.

8           (2) NATIONAL COMMITTEE ON VITAL AND  
9       HEALTH STATISTICS.—Section 306(k)(5) of the  
10      Public Health Service Act (42 U.S.C. 242(k)(5)) is  
11      amended—

12                (A) in subparagraphs (A)(viii) and (D), by  
13               striking “part C” and inserting “parts C and  
14               D”;

15                (B) in subparagraph (C), by striking  
16               “and” at the end;

17                (C) in subparagraph (D), by striking the  
18               period at the end and inserting “; and”; and

19                (D) by adding at the end the following:

20                “(E) shall study the issues relating to section  
21       1184 of the Social Security Act (as added by the Pa-  
22       tient Protection Act of 1998), and, not later than 1  
23       year after the date of the enactment of the Patient  
24       Protection Act of 1998, shall report to the Congress  
25       on such section.”.

1 (d) EFFECTIVE DATE.—The amendments made by  
2 this section shall take effect on the date that is 1 year  
3 after the date of the enactment of this Act, except that  
4 subsection (c)(2), and section 1183(b) of the Social Secu-  
5 rity Act (as added by subsection (a)), shall take effect on  
6 the date of the enactment of this Act.

7 **SEC. 5002. STUDY AND REPORT ON EFFECT OF STATE LAW**  
8 **ON HEALTH-RELATED RESEARCH.**

9 Not later than one year after the date of the enact-  
10 ment of this Act, the Comptroller General of the United  
11 States shall prepare and submit to the Congress a report  
12 containing the results of a study on the effect of State  
13 laws on health-related research subject to review by an in-  
14 stitutional review board or institutional review committee  
15 with respect to the protection of human subjects.

16 **SEC. 5003. STUDY AND REPORT ON STATE LAW ON PRO-**  
17 **TECTED HEALTH INFORMATION.**

18 (a) IN GENERAL.—Not later than 9 months after the  
19 date of the enactment of this Act, the Comptroller General  
20 of the United States shall prepare and submit to the Con-  
21 gress a report containing the results of a study—

22 (1) compiling State laws on the confidentiality  
23 of protected health information (as defined in sec-  
24 tion 1188 of the Social Security Act, as added by  
25 section 5001 of this Act); and

1           (2) analyzing the effect of such laws on the pro-  
2 vision of health care and securing payment for such  
3 care.

4           (b) MODIFICATION OF DEADLINE.—Section  
5 264(c)(1) of the Health Insurance Portability and Ac-  
6 countability Act of 1996 (Public Law 104–191; 110 Stat.  
7 2033) is amended by striking “36 months after the date  
8 of the enactment of this Act,” and inserting “6 months  
9 after the date on which the Comptroller General of the  
10 United States submits to the Congress a report under sec-  
11 tion 5003(a) of the Patient Protection Act of 1998,”.

12 **SEC. 5004. PROTECTION FOR CERTAIN INFORMATION DE-**  
13 **VELOPED TO REDUCE MORTALITY OR MOR-**  
14 **BIDITY OR FOR IMPROVING PATIENT CARE**  
15 **AND SAFETY.**

16           (a) PROTECTION OF CERTAIN INFORMATION.—Not-  
17 withstanding any other provision of Federal or State law,  
18 health care response information shall be exempt from any  
19 disclosure requirement (regardless of whether the require-  
20 ment relates to subpoenas, discovery, introduction of evi-  
21 dence, testimony, or any other form of disclosure), in con-  
22 nection with a civil or administrative proceeding under  
23 Federal or State law, to the same extent as information  
24 developed by a health care provider with respect to any  
25 of the following:

1 (1) Peer review.

2 (2) Utilization review.

3 (3) Quality management or improvement.

4 (4) Quality control.

5 (5) Risk management.

6 (6) Internal review for purposes of reducing  
7 mortality, morbidity, or for improving patient care  
8 or safety.

9 (b) NO WAIVER OF PROTECTION THROUGH INTER-  
10 ACTION WITH ACCREDITING BODY.—Notwithstanding any  
11 other provision of Federal or State law, the protection of  
12 health care response information from disclosure provided  
13 under subsection (a) shall not be deemed to be modified  
14 or in any way waived by—

15 (1) the development of such information in con-  
16 nection with a request or requirement of an accredit-  
17 ing body; or

18 (2) the transfer of such information to an ac-  
19 crediting body.

20 (c) DEFINITIONS.—For purposes of this section:

21 (1) The term “accrediting body” means a na-  
22 tional, not-for-profit organization that—

23 (A) accredits health care providers; and

1 (B) is recognized as an accrediting body by  
2 statute or by a Federal or State agency that  
3 regulates health care providers.

4 (2) The term “health care provider” has the  
5 meaning given such term in section 1188 of the So-  
6 cial Security Act (as added by section 5001 of this  
7 Act).

8 (3) The term “health care response informa-  
9 tion” means information (including any data, report,  
10 record, memorandum, analysis, statement, or other  
11 communication) developed by, or on behalf of, a  
12 health care provider in response to a serious, ad-  
13 verse, patient-related event—

14 (A) during the course of analyzing or  
15 studying the event and its causes; and

16 (B) for purposes of—

17 (i) reducing mortality or morbidity; or

18 (ii) improving patient care or safety

19 (including the provider’s notification to an  
20 accrediting body and the provider’s plans  
21 of action in response to such event).

22 (5) The term “State” has the meaning given  
23 such term in section 1188 of the Social Security Act  
24 (as added by section 5001 of this Act).

1 **TITLE VI—MEDICAL SAVINGS AC-**  
2 **COUNTS FOR FEDERAL EM-**  
3 **PLOYEES**

4 **SEC. 6001. MEDICAL SAVINGS ACCOUNTS FOR FEDERAL**  
5 **EMPLOYEES.**

6 (a) MEDICAL SAVINGS ACCOUNTS.—

7 (1) CONTRIBUTIONS.—Title 5, United States  
8 Code, is amended by redesignating section 8906a as  
9 section 8906c and by inserting after section 8906  
10 the following:

11 **“§ 8906a. Government contributions to medical sav-**  
12 **ings accounts**

13 “(a) An employee or annuitant enrolled in a high de-  
14 ductible health plan is entitled, in addition to the Govern-  
15 ment contribution under section 8906(b) toward the sub-  
16 scription charge for such plan, to have a Government con-  
17 tribution made, in accordance with succeeding provisions  
18 of this section, to a medical savings account of such em-  
19 ployee or annuitant.

20 “(b)(1) The biweekly Government contribution under  
21 this section shall, in the case of any such employee or an-  
22 nuitant, be equal to the amount by which—

23 “(A) the biweekly equivalent of the maximum  
24 Government contribution for the contract year in-

1       volved (as defined by paragraph (2)), exceeds (if at  
2       all)

3           “(B) the amount of the biweekly Government  
4       contribution payable on such employee’s or annu-  
5       itant’s behalf under section 8906(b) for the period  
6       involved.

7           “(2) For purposes of this section, the term ‘maximum  
8       Government contribution’ means, with respect to a con-  
9       tract year, the maximum Government contribution that  
10      could be made for health benefits for an employee or annu-  
11      itant for such contract year, as determined under section  
12      8906(b) (disregarding paragraph (2) thereof)).

13          “(3) Notwithstanding any other provision of this sec-  
14      tion, no contribution under this section shall be payable  
15      to any medical savings account of an employee or annu-  
16      itant for any period—

17           “(A) if, as of the first day of the month before  
18      the month in which such period commences, such  
19      employee or annuitant (or the spouse of such em-  
20      ployee or annuitant, if coverage is for self and fam-  
21      ily) is entitled to benefits under part A of title  
22      XVIII of the Social Security Act;

23           “(B) to the extent that such contribution, when  
24      added to previous contributions made under this sec-  
25      tion for that same year with respect to such em-



1       employee or annuitant, would cause the total to ex-  
2       ceed—

3               “(i) the highest annual limit deductible  
4               permitted under clause (i) or (ii) of section  
5               220(c)(2)(A) of the Internal Revenue Code of  
6               1986, as appropriate (determined taking into  
7               account any changes in coverage that may  
8               occur), for the calendar year in which such pe-  
9               riod commences; or

10              “(ii) such lower amount (relative to the  
11              limitation that would otherwise apply under  
12              clause (i)) as the employee or annuitant may  
13              specify in accordance with regulations of the  
14              Office, including an election not to receive con-  
15              tributions under this section for a year or the  
16              remainder of a year; or

17              “(C) for which any information (or documenta-  
18              tion) under subsection (d) that is needed in order to  
19              make such contribution has not been timely submit-  
20              ted.

21              “(4) Notwithstanding any other provision of this sec-  
22              tion, no contribution under this section shall be payable  
23              to any medical savings account of an employee for any  
24              period in a contract year unless that employee was en-

1 rolled in a health benefits plan under this chapter as an  
2 employee for not less than—

3 “(A) the 1 year of service immediately before  
4 the start of such contract year, or

5 “(B) the full period or periods of service be-  
6 tween the last day of the first period, as prescribed  
7 by regulations of the Office of Personnel Manage-  
8 ment, in which he is eligible to enroll in the plan and  
9 the day before the start of such contract year,  
10 whichever is shorter.

11 “(5) The Office shall provide for the conversion of  
12 biweekly rates of contributions specified by paragraph (1)  
13 to rates for employees and annuitants whose pay or annu-  
14 ity is provided on other than a biweekly basis, and for  
15 this purpose may provide for the adjustment of the con-  
16 verted rate to the nearest cent.

17 “(c) A Government contribution under this section—

18 “(1) shall be made at the same time that, and  
19 the same frequency with which, Government con-  
20 tributions under section 8906(b) are made for the  
21 benefit of the employee or annuitant involved; and

22 “(2) shall be payable from the same appropria-  
23 tion, fund, account, or other source as would any  
24 Government contributions under section 8906(b)  
25 with respect to the employee or annuitant involved.

1       “(d) The Office shall by regulation prescribe the time,  
2 form, and manner in which an employee or annuitant shall  
3 submit any information (and supporting documentation)  
4 necessary to identify any medical savings account to which  
5 contributions under this section are requested to be made.

6       “(e) Nothing in this section shall be considered to en-  
7 title an employee or annuitant to any Government con-  
8 tribution under this section with respect to any period for  
9 which such employee or annuitant is ineligible for a Gov-  
10 ernment contribution under section 8906(b).

11   **“§ 8906b. Individual contributions to medical savings**  
12                   **accounts**

13       “(a) Upon the written request of an employee or an-  
14 nuitant enrolled in a high deductible health plan, there  
15 shall be withheld from the pay or annuity of such employee  
16 or annuitant and contributed to the medical savings ac-  
17 count identified by such employee or annuitant in accord-  
18 ance with applicable regulations under subsection (c) such  
19 amount as the employee or annuitant may specify.

20       “(b) Notwithstanding subsection (a), no withholding  
21 under this section may be made from the pay or annuity  
22 of an employee or annuitant for any period—

23               “(1) if, or to the extent that, a Government  
24       contribution for such period under section 8906a

1 would not be allowable by reason of subparagraph  
2 (A) or (B)(i) of subsection (b)(3) thereof;

3 “(2) for which any information (or documenta-  
4 tion) that is needed in order to make such contribu-  
5 tion has not been timely submitted; or

6 “(3) if the employee or annuitant submits a re-  
7 quest for termination of withholdings, beginning on  
8 or after the effective date of the request and before  
9 the end of the year.

10 “(c) The Office of Personnel Management shall pre-  
11 scribe any regulations necessary to carry out this section,  
12 including provisions relating to the time, form, and man-  
13 ner in which any request for withholdings under this sec-  
14 tion may be made, changed, or terminated.”.

15 (2) RULES OF CONSTRUCTION.—Nothing in  
16 this section or in any amendment made by this sec-  
17 tion shall be considered—

18 (A) to permit or require that any contribu-  
19 tions to a medical savings account (whether by  
20 the Government or through withholdings from  
21 pay or annuity) be paid into the Employees  
22 Health Benefits Fund; or

23 (B) to affect any authority under section  
24 1005(f) of title 39, United States Code, to vary,  
25 add to, or substitute for any provision of chap-

1           ter 89 of title 5, United States Code, as amend-  
2           ed by this section.

3           (3) CONFORMING AMENDMENTS.—

4                   (A) The table of sections at the beginning  
5           of chapter 89 of title 5, United States Code, is  
6           amended by striking the item relating to section  
7           8906a and inserting the following:

“8906a.   Government contributions to medical savings accounts.  
“8906b.   Individual contributions to medical savings accounts.  
“8906c.   Temporary employees.”.

8                   (B) Section 8913(b)(4) of title 5, United  
9           States Code, is amended by striking  
10          “8906a(a)” and inserting “8906c(a)”.

11          (b) INFORMATIONAL REQUIREMENTS.—Section 8907  
12 of title 5, United States Code, is amended by adding at  
13 the end the following:

14          “(c) In addition to any information otherwise re-  
15 quired under this section, the Office shall make available  
16 to all employees and annuitants eligible to enroll in a high  
17 deductible health plan, information relating to—

18                   “(1) the conditions under which Government  
19          contributions under section 8906a shall be made to  
20          a medical savings account;

21                   “(2) the amount of any Government contribu-  
22          tions under section 8906a to which an employee or  
23          annuitant may be entitled (or how such amount may  
24          be ascertained);

1           “(3) the conditions under which contributions  
2           to a medical savings account may be made under  
3           section 8906b through withholdings from pay or an-  
4           nuity; and

5           “(4) any other matter the Office considers ap-  
6           propriate in connection with medical savings ac-  
7           counts.”.

8           (c) HIGH DEDUCTIBLE HEALTH PLAN AND MEDI-  
9           CAL SAVINGS ACCOUNT DEFINED.—Section 8901 of title  
10          5, United States Code, is amended—

11           (1) in paragraph (10) by striking “and” after  
12          the semicolon;

13           (2) in paragraph (11) by striking the period  
14          and inserting a semicolon; and

15           (3) by adding at the end the following:

16           “(12) the term ‘high deductible health plan’  
17          means a plan described by section 8903(5) or sec-  
18          tion 8903a(d); and

19           “(13) the term ‘medical savings account’ has  
20          the meaning given such term by section 220(d) of  
21          the Internal Revenue Code of 1986.”.

22          (d) AUTHORITY TO CONTRACT FOR HIGH DEDUCT-  
23          IBLE HEALTH PLANS.—Section 8902 of title 5, United  
24          States Code, is amended by adding at the end the follow-  
25          ing:

1       “(p)(1) The Office shall contract under this chapter  
 2 for a high deductible health plan with any qualified carrier  
 3 that offers such a plan and, as of the date of enactment  
 4 of the Federal Employees Health Care Freedom of Choice  
 5 Act, offers a health benefits plan under this chapter.

6       “(2) The Office may contract under this chapter for  
 7 a high deductible health plan with any qualified carrier  
 8 that offers such a plan, but does not, as of the date of  
 9 enactment of the Federal Employees Health Care Free-  
 10 dom of Choice Act, offer a health benefits plan under this  
 11 chapter.”.

12       (e) DESCRIPTION OF HIGH DEDUCTIBLE HEALTH  
 13 PLANS AND BENEFITS TO BE PROVIDED THERE-  
 14 UNDER.—

15           (1) IN GENERAL.—Section 8903 of title 5,  
 16 United States Code, is amended by adding at the  
 17 end the following:

18           “(5) HIGH DEDUCTIBLE HEALTH PLANS.—(A)  
 19 One or more plans described by paragraph (1), (2),  
 20 (3), or (4), which—

21                   “(i) are high deductible health plans (as  
 22 defined by section 220(c)(2) of the Internal  
 23 Revenue Code of 1986); and

24                   “(ii) provide benefits of the types referred  
 25 to by section 8904(a)(5).

1           “(B) Nothing in this section shall be consid-  
2       ered—

3           “(i) to prevent a carrier from simulta-  
4       neously offering a plan described by subpara-  
5       graph (A) and a plan described by paragraph  
6       (1) or (2); or

7           “(ii) to require that a high deductible  
8       health plan offer two levels of benefits.”.

9       (2) TYPES OF BENEFITS.—Section 8904(a) of  
10      title 5, United States Code, is amended by inserting  
11      after paragraph (4) the following:

12           “(5) HIGH DEDUCTIBLE HEALTH PLANS.—Ben-  
13      efits of the types named under paragraph (1) or (2)  
14      of this subsection or both.”.

15      (3) CONFORMING AMENDMENTS.—

16           (A) Section 8903a of title 5, United States  
17      Code, is amended by redesignating subsection  
18      (d) as subsection (e) and by inserting after sub-  
19      section (c) the following:

20           “(d) The plans under this section may include one  
21      or more plans, otherwise allowable under this section, that  
22      satisfy the requirements of clauses (i) and (ii) of section  
23      8903(5)(A).”.



1 (B) Section 8909(d) of title 5, United  
 2 States Code, is amended by striking  
 3 “8903a(d)” and inserting “8903a(e)”.

4 (4) REFERENCES.—Section 8903 of title 5,  
 5 United States Code, is amended by adding after  
 6 paragraph (5) (as added by paragraph (1) of this  
 7 subsection) as a flush left sentence, the following:  
 8 “The Office shall prescribe regulations in accordance with  
 9 which the requirements of section 8902(c), 8902(n),  
 10 8909(e), and any other provision of this chapter that ap-  
 11 plies with respect to a plan described by paragraph (1),  
 12 (2), (3), or (4) of this section shall apply with respect to  
 13 the corresponding plan under paragraph (5) of this sec-  
 14 tion. Similar regulations shall be prescribed with respect  
 15 to any plan under section 8903a(d).”.

16 **SEC. 6002. EFFECTIVE DATE.**

17 The amendments made by this title shall apply with  
 18 respect to contract years beginning on or after January  
 19 1, 2000. The Office of Personnel Management shall take  
 20 appropriate measures to ensure that coverage under a  
 21 high deductible health plan under chapter 89 of title 5,  
 22 United States Code (as amended by this section) shall be  
 23 available as of the beginning of the first contract year de-  
 24 scribed in the preceding sentence.

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